Summary Plan Description

UnitedHealthcare

Health Reimbursement Account (HRA)

Wellness Plan

for the

State Health Benefit Plan

Group Number: 702030
Effective Date: January 1, 2013

Table of Contents

Introduction 6

How to Use this Document 6
Information about Defined Terms 7
Fraud and Abuse 7
Your Contribution Requirements 7
Customer Service and Claims Submittal 7
Wellness Features 9
Tobacco Cessation Telephonic Coaching Program 9
Tobacco Surcharge 9
New SHBP Web Portal - AHealthierSHBP.com 9
Wellness Benefit Plan Incentive 10

Section 1: What's Covered under this HRA Option --Benefits 20

Accessing Benefits 20
Coinsurance 21
HRA Plan Highlights 21
How the HRA Option Works 22
Requesting Reimbursement From Your HRA 23
Eligible Expenses 24
Payment Information 27
Annual Deductible 27
Out-of-Pocket Maximum 28
HRA Credit 29
Lifetime Maximum* 30
Benefit Information 31
1. Ambulance Services - Emergency only 31
2. Dental Services and Oral Care Surgery: 32
3. Durable Medical Equipment 36
4. Emergency Health Services 39
5. Eye Examinations 39
6. Hearing Services 40
7. Home Health Care 41
8. Hospice Care 43
9. Hospital - Inpatient Stay 44
10. Infertility Services 45
11. Injections 46
12. Inpatient Rehabilitation Facility Services 46
13. Maternity (Physician Services for prenatal, delivery and postpartum) 47
14. Mental Health Services 49
15. Nutritional Counseling/Childhood Obesity 52
16. Ostomy and Urinary Catheter Supplies 54
17. Outpatient Surgery, Diagnostic and Therapeutic Services 55
18. Physician's Office Services 57
19. Professional Fees for Surgical and Medical Services 58
20. Prosthetic Devices 58
21. Reconstructive Procedures 60
22. Rehabilitation Services - Outpatient Therapy 62
23. Skilled Nursing Facility 64
24. Spinal Treatment, Chiropractic and Osteopathic Manipulative Therapy 65

25. Substance Use Disorder Services 66
26. Transplantation Services 69
27. Urgent Care Center Services 73
28. Wigs 73

Section 2: What's Not Covered Under this HRA Option-- Exclusions 74

How We Use Headings in this Section 74
No Benefits for Exclusions 74
A. Alternative Treatments 74
B. Comfort or Convenience 75
C. Dental 75
D. Drugs **Please refer to your Outpatient Prescription Drug Rider 75
E. Experimental, Investigational or Unproven Services 76
F. Foot Care 76
G. Medical Supplies and Appliances 76
H. Mental Health/Substance Use Disorder 77
I. Nutrition 79
J. Physical Appearance 79
K. Providers 80
L. Reproduction 80
M. Services Provided under Another Plan 80
N. Transplants 80
O. Travel 81
P. Vision and Hearing 81
Q. All Other Exclusions 81

Section 3: Description of Network and Out-of-Network Benefits Under this HRA Option 84

Network Benefits 84
Out-of-Network Benefits 86
Emergency Health Services 87

Section 4: Eligibility for SHBP as an Active Employee; When Coverage as an Active Employee Begins and Ends 88

How to Enroll 88
If You Are Hospitalized When Your Coverage Begins 88
Who is Eligible for Coverage 89
Eligible Person 89
Dependent 93
When to Enroll and When Coverage Begins 96
Contributions Surcharge Policy 96
Enrollment Periods 98
Enrolling A Newly Eligible Dependent 100
When Coverage Begins 102
Adding Dependents 104
Within 31 days of the child becoming disabled and the disabled dependent child: 105
Qualifying Events that Allow Coverage Changes for Active Employee Members 107
Open Enrollment and Retiree Option Change Period 117
General Information about When Coverage Ends 117
Events Ending Your Coverage as an Active Employee 119

Section 5: Eligibility as a Former Employee with 8 or more Years of Service or as an Annuitant: When coverage as a Former Employee or Annuitant Begins and Ends 122

Plan Membership 122
Eligibility 123
Eligibility as an Annuitant 124
Applying for Coverage Continuation as an Annuitant 125
When Annuitant Coverage Begins 126
When Coverage as a Former Employee (non-Annuitant) Begins ... 126
When Will Coverage as an Annuitant or Former Employee End? 126
Continuing Dependent Coverage at Your Death (for Annuitants) 127
Making Changes to Your Retiree Coverage (for all Former Employees and Annuitants) 128
Discontinuing Your Retiree Coverage or Discontinuing Your Dependent Coverage (for all Former Employees and Annuitants) 129
Qualifying Events for all Former Employees and Annuitants 130
Retiree Option Change Period (ROCP) 135
If You Return to Active Employee Status 135
Medicare Coordination of Benefits for all Former Employees and Annuitants 136
Frequently asked Medicare Questions 137

Section 6: How to File a Claim 138

If You Receive Covered Health Services from a Network Provider 138
Filing a Claim for Benefits* 138

Section 7: Questions, Complaints and Appeals 142

What to Do First 142
Appeal Process – How to Appeal an Eligibility Decision 143
How to Appeal a Medical or Pharmacy Claim Determination 144
Urgent Claim Appeals that Require Immediate Action 145
Voluntary External Review Program 145

Section 8: Coordination of Benefits 146

Filing a Claim When Coordination of Benefits (COB) applies 146
How COB Works 147
How to Tell Which Plan is Primary 147
If You Have Dual Plan Coverage 148
Other Forms of Duplicated Benefits 148

Section 9: Continuation of Coverage under COBRA and During Leave 149

When Coverage may be Continued 149
Unpaid Leaves of Absence 149
Continuing Coverage during Approved Disability Leave 150
Continuing Coverage under Family and Medical Leave Act (FMLA) 150
Continuing Coverage during Military Leave 151
If You Leave Your Job With Less than 8 Years of Service 151
In the Event of Your Death During Active Employment 152
Continuation Coverage under Federal Law (COBRA) 152

Qualifying Events for Continuation Coverage under Federal Law (COBRA) ... 152
Notification Requirements and Election Period for Continuation Coverage under Federal Law (COBRA) ... 153
Terminating Events for Continuation Coverage under Federal Law (When COBRA Coverage Ends) ... 154

Section 10: General Legal Provisions ... 156
Plan Document ... 156
Relationship with Providers ... 156
Your Relationship with Providers ... 156
Incentives to You ... 157
Interpretation of Benefits ... 157
Administrative Services ... 157
Clerical Error ... 157
Information and Records ... 157
Examination of Covered Persons ... 158
Workers' Compensation not Affected ... 158
Subrogation and Reimbursement ... 158
Refund of Overpayments ... 159
Limitation of Action ... 159

Section 11: Your Rights and Responsibilities 160
Active Employee Rights and Responsibilities ... 160
Former Employee and Annuitant Rights and Responsibilities ... 163

Section 12: Department of Community Health, State Health Benefit Plan Notices ... 165
HIPAA Privacy Notice ... 165

Section 13: Glossary of Defined Terms for this HRA Option ... 169

Riders, Amendments, Notices ... 188

Outpatient Prescription Drug Rider for this HRA Option ... 190

Introduction ... 191
Benefits for Outpatient Prescription Drug Products ... 191
Coverage Policies and Guidelines ... 191
Preventive Care Medications ... 192
Tobacco Cessation Medications ... 192
Identification Card (ID Card) – Network Pharmacy ... 193
Designated Pharmacies ... 193
Specialty Designated Pharmacy Network ... 193
Limitation on Selection of Pharmacies ... 194
Special Programs ... 194
Member Rights and Responsibilities ... 194
UnitedHealthcare Disclaimer ... 194

Section 1: What's Covered--Prescription Drug Benefits ... 195
Benefits for Outpatient Prescription Drug Products ... 195
When a Brand-name Drug Becomes Available as a Generic ... 195

Supply Limits 195
Notification (also known as Prior Authorization or Coverage Review) Requirements 196
Step Therapy Program Requirements 197
Clinical Appeal Process 197
How to Fill Your Prescription At An Out-of-Network Pharmacy or At a Network Pharmacy When you Do Not Present Your ID Card 198
Coordination of Benefits (COB) 199
What You Must Pay 200

Section 2: What's Not Covered--Exclusions . 209

Section 3: Glossary of Defined Terms 211

Section 4: Frequently Asked Questions 214
What is a Prescription Drug List (PDL)? 214
Understanding Tiers 214
What factors are looked at when making tier placement decisions and who decides which medications get placed in which tier? 215
How often will prescription medications change tiers? 215
What is the difference between brand name and generic medications? 215
Why is the medication that I am currently taking no longer covered? 216
When should I consider discussing over-the-counter or non-prescription medications with my doctor? 216
What is a maintenance medication program? 216
What maintenance medications are included in the maintenance medication program? 216
What are the Supply Limits (SL) programs? 216
How do the Supply Limit programs work? 217
What is the Notification program? 217
How does the Notification program work? 217
What should I do if I use a self-administered injectable medication? 217
How do I obtain a supply of my medications before I go on vacation? 217
How do I access updated information about my pharmacy benefit? 218
What if I still have questions? 218

Attachment I 219
Women's Health and Cancer Rights Act of 1998 219
Statement of Rights under the Newborns' and Mothers' Health Protection Act 219

Attachment II 220
Patient Protection and Affordable Care Act ("PPACA") 220

Attachment III 221
Health Insurance Portability and Accountability Act 221

Attachment IV 224
Election to be Exempt from Certain Requirements of HIPAA 224

Introduction

This booklet is your Summary Plan Description (SPD) and describes the provisions of the State Health Benefit Plan (SHBP) and this Health Reimbursement Account (HRA) Wellness Option under the State Health Benefit Plan. This Health Reimbursement Wellness Plan Option is referred to in this booklet as the "HRA Wellness Option" and the State Health Benefit Plan is referred to as the "SHBP" or "the Plan." You have this SPD because you are enrolled in the HRA Wellness Option under the SHBP and you made the Wellness Promise. Use this SPD as a reference tool to help and maximize your coverage.

The SHBP consists of three plans established by Georgia law: a plan for State employees, a plan for public school teachers, and a plan for public school employees other than teachers. The SHBP is self-insured Plan, and is governed by certain Georgia laws, the regulations of the Department of Community Health (DCH) Board, Chapter 111-4-1 Health Benefit Plan, and resolutions of the Board of Community Health that establish required contributions that must be paid to the SHBP. If there are discrepancies between the information in this SPD and DCH Board regulations or the laws of the state of Georgia, or the Board resolutions setting required contributions, those regulations, laws and resolutions will govern at all times.

This booklet is notice to all Covered Persons of the Plan's eligibility requirements and benefits payable under the HRA Option for services provided on or after January 1, 2013, unless otherwise noted. Any and all statements to Covered Persons or to providers about eligibility, payment or levels of payment that were made before January 1, 2013 are canceled if they conflict in any way with the provisions described in this booklet.

The Department of Community Health is the Plan Administrator, and reserves the right to act as sole interpreter of all the terms and conditions of the Plan, except where expressly delegated to the Claims Administrator. The Plan Administrator has delegated full responsibility for claims administration to UnitedHealthcare, the Claims Administrator for the Plan. The Claims Administrator processes and pays claims in accordance with the terms of the Plan, including this booklet and the separate medical policy guidelines that serve as supplement to this booklet to more fully define eligible charges. The Claims Administrator has the discretion to interpret the terms of the Plan when processing and paying claims and makes final decisions with respect to medical and pharmacy claims.

The Department of Community Health also reserves the right to modify the benefits, level of benefit coverage and eligibility/participation requirements for the Plan at any time, subject only to reasonable notification to Members. When such a change is made, it will apply as of the modification's effective date to any and all charges incurred by Members on that day and after, unless otherwise specified by the DCH.

How to Use this Document

We encourage you to read your SPD and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitations of this SPD by reading Section 1: What's Covered--Benefits and Section 2: What's Not Covered--Exclusions. You should also carefully read Section 10: General Legal Provisions to better understand how this SPD and your Benefits work. You should call UnitedHealthcare if you have questions about the limits of the coverage available to you.

Many of the sections of the SPD are related to other sections of the document. You may not have all of the information you need by reading just one section. We also encourage you to keep your SPD and any attachments in a safe place for your future reference.

Please be aware that your Physician does not have a copy of your SPD and is not responsible for knowing or communicating your Benefits.

Information about Defined Terms

Because this SPD is a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in Section 11: Glossary of Defined Terms. You can refer to Section 11 as you read this document to have a clearer understanding of your SPD.

When we use the words "we", "us", and "our" in this document, we are referring to the Department of Community Health, Division of SHBP. When we use the words "you" and "your" we are referring to people who are Covered Persons as the term is defined in Section 11: Glossary of Defined Terms.

Fraud and Abuse

Please notify the Plan of any fraudulent activity regarding Plan members, providers, payment of benefits, etc. Call 1-866-242-7727.

Your Contribution Requirements

All Members are required to make regular contributions (called premiums) in order to maintain coverage. All contributions by active employees must be made through salary deductions. Contributions by former employees must be made through annuity deductions, if possible, or through direct payments. The Board of Community Health sets the contribution requirements by resolution. Usually the contribution requirements are set on an annual basis before Open Enrollment and the Retiree Option Change Period, but contributions may be changed by the Board at any time, subject to advance notice. It is the Member's responsibility to make sure that the contributions paid are appropriate for the plan option selected. Contact your benefits representative for information about the required contributions you are responsible for paying.

Customer Service and Claims Submittal

Please make note of the following information that contains UnitedHealthcare department names and telephone numbers.

Customer Service Representative (i.e. questions regarding Coverage or procedures): 1-800-396-6515. TDD phone # is 1-800-255-0056.

Monday - Friday 8:00 a.m. – 8:00 p.m.

Prior Authorization / Care Coordination: 1-800-955-7976.

For detailed explanation on Prior **Authorization** please see page 7.

Mental Health/Substance Use Disorder Services:
1-800-396-6515

Pharmacy Questions: 1-800-396-6515

Plan's Eligibility Unit: 1-800-610-1863, toll-free

Monday - Friday, 8:30 a.m. to 4:30 p.m.

Membership Correspondence and Appeals for eligibility issues and issues other than medical or pharmacy claims:

State Health Benefit Plan

Membership Correspondence Unit

P.O. Box 1990, Atlanta, GA 30301-1990

Note: For forms and procedures go to www.dch.georgia.gov/shbp.

Membership Correspondence and Appeals for issues related to completing the 2013 Wellness Promise:

Please see the Wellness Benefit Plan Incentive section of this booklet for information about how to correspond with UnitedHealthcare about the 2013 Wellness Promise requirements and appeal an adverse determination
Claims Submittal Address:

United HealthCare Services, Inc.

Attn: Claims

PO Box 740806

Atlanta, GA 30374-0806

Requests for Review of Denied Claims/ Appeals and Notice of Complaints:

United HealthCare Services, Inc.

PO Box 30994

Salt Lake City, Utah 84130-0994

Note: UnitedHealthcare reserves the right to request medical records and any other supporting documentation for medical and pharmacy claims submitted.

Written appeals and inquiries related to the Prescription Drug Program should be directed to:

State of Georgia Health Benefit Plan Members

6220 Old Dobbin Lane

Columbia, MD 21045

Wellness Features

Tobacco Cessation Telephonic Coaching Program

The Tobacco Cessation Telephonic Coaching program is available to Covered Persons age 18 and over to assist them to become tobacco free. Prescription and Over-The-Counter (OTC) tobacco cessation therapies (including Nicotine Replacement Therapy (NRT)) are available for one cycle of OTC or prescription medication as defined below (also defined as one cessation attempt) per plan year. A Covered Person participating in the program must meet the following requirements: 1) Wellness Coach confirms member's program eligibility and member's program enrollment; 2) member selects a "quit date"; 3) member obtains a prescription for OTC or Prescribed NRT from their physician; 4) member calls and notifies the Wellness Coach of receipt of the prescription and the medication prescribed; and 5) member remains actively engaged with their Wellness Coach for the duration of the Tobacco Cessation Telephonic Coaching Program.

NOTE: Selected tobacco cessation medications will be covered as described in the Outpatient Prescription Drug Rider: 1) a one-time cycle of OTC tobacco cessation medications is available through Retail Network Pharmacy for 8-weeks therapy at no cost to the member. A 31- day supply will be dispensed for the OTC medication. 1) fill and 1 refill and a prescription is required for coverage. 2) A one-time cycle of Prescription tobacco cessation medications is available through Retail Network Pharmacy for 12-weeks of therapy. The applicable pharmacy coinsurance will apply. A 31- day supply will be dispensed for the Prescription medications; 1 fill and 2 refills.

You and your covered dependents 18 years of age or older are allowed to enroll in the coaching program as many times as you like or feel you need. For the medication coverage portion of this program, the SHBP will pay for one cycle of Over The-Counter (OTC) tobacco cessation medication or one cycle of Prescription tobacco cessation medication. If additional cycles of tobacco cessation medications over the allowed one medication attempt covered by the SHBP within the plan year is required please note this will be covered at your own expense. Please call UnitedHealthcare Telephonic Health Coaching @ 1-800-478-1057 to enroll in the Tobacco Cessation Program.

Tobacco Surcharge

Tobacco surcharges are included in all SHBP Options other than Medicare Advantage Options. These surcharges are intended to promote tobacco cessation and use of the Tobacco Cessation Telephonic Coaching Program. Please see the www.dch.georgia.gov to access the tobacco surcharge removal policies and forms.

New SHBP Web Portal - AHealthierSHBP.com

AHealthierSHBP.com provides an online interactive health educational experience for SHBP Members, enrolled Spouses and dependent children. AHealthierSHBP is a health and wellness destination that serves to generate awareness and a deeper understanding of key aspects of SHBP resources. One component of AHealthierSHBP.com is a selection of interactive online health educational modules. Each interactive online health module ("online module") will take approximately 7-10 minutes to complete and provides valuable information about important health and wellness topics. If you do not have access to the internet at home or work, we recommend that you access AHealthierSHBP through a family member, friend or public library.

Wellness Benefit Plan Incentive

Members enrolled in any 2013 SHBP WELLNESS Plan Option are paying lower premium contributions and receiving richer plan benefits because they made a 2013 Wellness Promise and either kept the 2012 Wellness Promise (if they were enrolled in a 2012 SHBP Wellness Plan Option) or enrolled in a WELLNESS Plan Option for the first time and were previously not covered or were covered under a Standard Plan Option in 2012.

2013 Wellness Requirements

Group 1: Members who were enrolled in a 2012 SHBP Wellness Plan Option and met the 2012 Wellness Promise

Members who were enrolled in a 2012 Wellness Plan Option are eligible for this 2013 SHBP Wellness Plan Option because they met the 2012 Wellness Promise. These Members made the 2013 Wellness Promise and these Members and their Spouses (if covered) are required to take the following **two** health actions* to meet the 2013 Wellness Requirements.

1. You and your Spouse (if covered) must each complete an online module through the SHBP Member Education Portal at AHealthierSHBP.com between January 1, 2013 and 4:30pm EDT May 31, 2013. Please print a confirmation of completion; **AND**

2. You and your Spouse (if covered) must each complete the online Health Assessment through www.myuhc.com between January 1, 2013, and 4:30pm EDT May 31, 2013. Please print confirmation of completion.

*IMPORTANT – A **newly enrolled** Spouse (for 2013) must complete three health actions to meet the 2013 Wellness Requirements. In addition to the two requirements above, a newly enrolled Spouse must complete a biometric screening (including body mass index (BMI), blood pressure, cholesterol, and glucose) through a physician's office between July 1, 2011 and 4:30pm EDT May 31, 2013. The physician must complete the 2013 Physician Screening Form showing all test results and fax to the number shown on the form between November 1, 2012, and 4:30pm EDT May 31, 2013.

Group 2: Members who were not enrolled in a 2012 SHBP Wellness Plan Option

Members who selected a 2013 SHBP Wellness Plan Option and were not enrolled in a 2012 SHBP Wellness Plan Option made the 2013 Wellness Promise and these Members and their Spouses (if covered) are required to take the following **three health actions to meet the 2013 Wellness Requirements:**:

1. You and your Spouse (if covered) must each complete an online module through the SHBP Member Education Portal at AHealthierSHBP.com between January 1, 2013, and 4:30pm EDT May 31, 2013. Please print a confirmation of completion;

2. You and your Spouse (if covered) must each complete the online Health Assessment through www.myuhc.com between January 1, 2013, and 4:30pm EDT May 31, 2013. Please print confirmation of completion; **AND**

3. You and your Spouse (if covered) must each complete a biometric screening (including body mass index (BMI), blood pressure, cholesterol, and glucose) through a physician's office between July 1, 2011 and 4:30pm EDT May 31, 2013. The physician must complete the 2013 Physician Screening Form showing all test results and fax to the number shown on the form between November 1, 2012, and 4:30pm EDT May 31, 2013.

Note: Biometric screenings may be performed through Out-of-Network or Network physicians. You will pay the full cost of the screening if it is performed by an Out-of-Network physician.

Biometric screenings performed through Network physicians are considered preventive and are covered at 100% if properly coded as preventive care.

The 2013 Physician Screening Form is available on November 1, 2012 at www.myuhc.com. If a biometric screening was completed July 1, 2011 or after, but prior to the 2013 Physician Screening Form being available, it will be necessary to contact the physician and have him or her fill out the 2013 Physician Screening Form completely and legibly, and fax it by 4:30pm EDT May 31, 2013. Please retain a copy of your screening results from your physician for your records.

UnitedHealth Personal Scorecard

In order to optimize your health care plan, and allow you to become as engaged as possible in your health, UnitedHealthcare provides helpful information and preventive care recommendations through the UnitedHealth Personal Rewards online and paper Personal Scorecard.

All 2013 SHBP Wellness Plan Options administered by UnitedHealthcare are powered by the UnitedHealth Personal Rewards online and paper Personal Scorecard. In addition to providing helpful recommendations about preventive care, the Personal Scorecard will help you keep track of whether you have completed your health assessment, an online module and biometric screening. Your Personal Scorecard will not show the health actions for your covered Spouse. Your covered Spouse will have his or her own Personal Scorecard.

To view your Personal Scorecard, you must register online at uhcrewards.healthinsight.com/shbp using the exact information displayed on your UnitedHealthcare Medical ID card. Your covered Spouse must also register online using the exact information displayed on his or her UnitedHealthcare Medical ID card to see his/her Personal Scorecard. You may also call the phone number on the back of your UnitedHealthcare Medical ID card to obtain information on your Personal Scorecard.

Timelines for Health Actions to be posted to your Personal Scorecard:

2013 online Personal Scorecards will be live on February 1, 2013. It will take approximately 30 business days after completion of health actions for the online Personal Scorecards to be updated.

- When you login to AHealthierSHBP.com and complete an online module between January 1, 2013, and 4:30pm EDT May 31, 2013, your Personal Scorecard will be updated to show 50 points.

- When you complete your online health assessment between January 1, 2013, and 4:30pm EDT May 31, 2013, your Personal Scorecard will be updated to show 50 points.

- When the biometric screening is completed between July 1, 2011, and 4:30pm EDT May 31, 2013 and a completed 2013 Physician Screening Form is successfully faxed to the number on the form by 4:30 p.m. EDT May 31, 2013, your Personal Scorecard will be updated to show 50 points.

If your Personal Scorecard is not properly updated within 30 business days of completion, please call the number on the back of your United Healthcare Medical ID card. [NOTE: If your Personal Scorecard does not show 50 points for completion of the online module and/or 50 points for completion of the online health assessment within 30 business days after completion, you may need to submit the 2013 UHC Health Module Member Notification Form and/or the 2013 UHC Health Assessment Member Notification Form (together with the corresponding Confirmation Statements) in accordance with the directions on the forms. The 2013 UHC Health Module Member Notification Form and the 2013 UHC Health

Assessment Member Notification Form are available at www.myuhc.com.] If submission of the form(s) and the necessary documentation satisfies the requirements for completion of the health action(s), your Personal Scorecard will be updated within 30 business days of submission.]

If the 2013 Physician Screening Form is incomplete, your Personal Scorecard will reflect partial data that can be processed. You will need to have the physician's office complete the remainder of the information and re-fax the 2013 Physician Screening Form by the May 31, 2013 deadline.

N**ote:** If you met the 2012 Wellness Promise requirements and selected a 2013 SHBP Wellness Plan Option, you do **not** need to complete another biometric screening. Please do **not** re-submit the biometric screening information. In most cases, your Personal Scorecard will show 50 points and the results of your 2012 Wellness Promise biometric screening on February 1, 2013. However, if you submitted biometric screening information as part of a Wellness appeal between August 3, 2012 and January 31, 2013, your Personal Scorecard should be updated to show the 50 points and the screening results no later than April 1, 2013. If your Personal Scorecard is not updated, please call the number on the back of your UnitedHealthcare Medical ID card.

If you and your covered Spouse each show 150 points on your individual Personal Scorecards (a combined 300 points), you will each have met your 2013 Wellness Promise requirements, and you will be entitled to the maximum Wellness incentives in 2014.

Sample Personal Scorecard for "Mary Winters."

This sample Personal Scorecard shows that "Mary Winters," (not a real person) has completed the 2013 Wellness Requirements. "Mary Winters" is a 60 year old woman managing diabetes. The table describes the health actions she took and the points she accumulated:

UnitedHealth Personal Rewards℠
A UnitedHealthcare Program

UnitedHealthcare®

Scorecard for MARY WINTERS (January, 2013)

The items below summarize your 2013 health actions. The required health actions include completion of an Online Health Assessment, completion of an Interactive Online Health Education module and a Biometric Screening. In order to complete the Biometric Screening, the results from the four biometric screenings (blood pressure, body mass index, cholesterol and glucose) must be submitted to the fax number on the 2014 Physician Screening Form by 4:30pm EDT on May 31, 2013. **The biometric screening requirement applies only to members and spouses (if covered) in a SHBP Plan option (HRA, HMO, HDHP Wellness or Standard Plan) who did not meet the biometric screening requirement of the 2012 Wellness Promise.**

You have earned 150 points!

The scorecard shows points for each 2013 Health Action you have satisfied. Members and spouses (if covered) will receive their own individual scorecards and must each earn 150 points to satisfy the requirements. The Online Health Assessment must be completed at myuhc.com between 1/1/2013 and 4:30 pm EDT on 5/31/2013. An Interactive Online Health Education module must be completed at www.AHealthierSHBP.com between 1/1/2013 and 4:30 pm EDT on 5/31/2013. Members and spouses (if covered) who did not meet the biometric screening component of the 2012 Wellness Promise must complete a biometric screening between 7/1/2011 and 5/31/2013, and have the physician submit the completed 2013 Physician Screening Form to the fax number on the form between 11/1/2012 and 4:30 pm EDT on 5/31/2013.

Your Health Actions	Points Available	Points Earned	Target[1] Test Value	Actual Test Value
Complete Health Assessment[2]	Achieved	50		
Complete an Interactive Online Health Education module[2]	Achieved	50		
Complete and submit all four Biometric Testing Values[2,5]	Achieved	50		
BMI biometric[3,4]	0	0	< 30 kg/m2	31
LDL biometric[3,4]	0	0	< 130	132
Blood Sugar biometric[3,4]	0	0	Non Fasting < 200 or Fasting < 100	99
Blood Pressure biometric[3,4]	0	0	<140/90	150/85
Complete Mammography *(Recommended)*[4]				
Complete Colorectal Cancer screening *(Recommended)*[4]				
Complete Cervical Cancer screening *(Recommended)*[4]				
Diabetes - Dilated Eye exam *(Recommended)*[4]				
Diabetes - 2nd Hemoglobin A1c test *(Recommended)*[4]				
Diabetes - Creatinine or Urine Protein test *(Recommended)*[4]				

[1]Target Test Values are based on generally recommended health standards. They may be different from targets recommended by your physician and should not replace the care plan designed by you and your physician.

[2]Due to provider processing time, it can take up to 60 days for points to post on this scorecard for "Your Health Actions" taken.

[3]The points sections read "0" because there are no points available or awarded for achieving Target Test Values, however, to meet the 2013 biometric requirements, you must submit all 4 biometric screenings [Body Mass Index (BMI), Low Density Lipoprotein (LDL), Blood Sugar and Blood Pressure].

[4]These actions are for you to consider and discuss with your physician. The back of the scorecard provides helpful resources. Please note you may not have any *recommended* health actions due to your age, gender and medical history.

[5]If you and your spouse (if covered) were enrolled in a Wellness Plan option for 2012 and each met the requirements of the 2012 Wellness Promise (which required a biometric screening), you will each automatically earn 50 points on the 2013 scorecard.

UnitedHealth Personal Rewards℠
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Take the next steps: Your Resources

Your Health Actions: *Get Started*	When & Where
Health Assessment	Must be completed at myuhc.com between 1/1/2013 and 4:30 pm EDT on 5/31/2013
Health Education Module	Must be completed at www.AHealthierSHBP.com between 1/1/2013 and 4:30 pm EDT on 5/31/2013
Biometric Testing	Members and spouses (if covered) who did not meet the biometric screening component of the 2012 Wellness Promise must complete a biometric screening including body mass index (BMI), blood pressure, LDL cholesterol and glucose by visiting their physician between 7/1/2011 and 5/31/2013. The physician must submit a completed Physician Screening Form to the fax number on the form between 11/1/2012 and 4:30 pm EDT on 5/31/2013. The form for the biometric screening and detailed instructions can be found at **myuhc.com**. If you met the Wellness Promise in 2012 and enrolled in a Wellness Plan for 2013, the biometric screening requirement does not apply to you.
BMI (Body Mass Index)	
LDL (Low Density Lipoprotein)	
Blood Sugar	
Blood Pressure	

The Health Actions below are recommendations provided for your consideration and discussion with your provider.

Your Health Actions: *Go Further*	When & Where
Screening – Mammography	Every two years at a provider's office or an outpatient facility
Screening – Colorectal Cancer	Varies by screening type at a provider's office or an outpatient facility
Screening – Cervical Cancer	Every three years at a provider's office or an outpatient facility

Diabetes – Hemoglobin A1c (HbA1c) second test	Twice per year at a provider's office
Diabetes – Dilated Eye exam	Annually at a provider's office
Diabetes – Creatinine or Urine Protein test	

The recommended health actions on your scorecard are created using information from the claims filed when you use your benefits. UnitedHealthcare then compares your health actions, as evidenced by those claims, to your life stage. Your recommended actions are derived from that comparison.	**GO GREEN!** To get your personalized statement online and/or suppress future statement mailings, visit: **uhcrewards.healthinsight.com/shbp**
Questions? Learn more! Visit uhcrewards.healthinsight.com/shbp, or www.myshbp.ga.gov or call the number on your UHC Medical ID Card	
We respect your right to privacy. Our business practices are in full compliance with the privacy requirements under the Health Insurance Portability and Accountability Act (HIPAA). Please review the SHBP Notice of Privacy Practices at www.dch.georgia.gov to learn how your information is used and protected in accordance with the law.	

MARY WINTERS

123 MAIN STREET

MY TOWN, USA 12345-6789

Correction of 2013 Physician Screening Forms

If the 2013 Physician Screening Form submitted by your physician is incomplete your Personal Scorecard will reflect partial data that can be processed. In order to have complete information updated on your Personal Scorecard, you will need to work with your physician's office to ensure that the form is corrected and submitted by the deadline of 4:30 p.m. EDT on May 31st, 2013.

Wellness Appeals Rights under all 2013 SHBP Wellness Plan Options powered by UnitedHealth Personal Rewards

Between July 1, 2013, and August 2, 2013, you and your Spouse (if covered) may appeal the total points applied on your online Personal Scorecard if the total points are less than you believe should have been credited to you or your Spouse. Keep proof that you completed the requirements. For example, keep proof of your office visit to a physician for the biometric screening (if applicable), and a copy of the completed 2013 Physician Screening Form (if applicable). When you complete the online Health Assessment through myuhc.com, print a copy of the statement that shows the date of completion. When you complete the online module, print a copy of the statement that shows the date of completion. Remember – you must login to AHealthierSHBP.com and complete an online module in order to receive credit for completing it.

Depending on which 2013 Wellness Requirements you are appealing, you will need to submit one or more of the following appeals (as applicable); 1. Health Assessment Appeals must be prepared on the 2013 UHC Health Assessment Appeals Form and submitted by fax to the number on the Form by 4:30pm EDT August 2, 2013, 2. Biometric Screening Appeals must be prepared on the 2013 Biometric Screening Appeal Form and submitted by fax to the number on the Form by 4:30 pm EDT August 2, 2013. 3. Health Module Appeals must be prepared on the 2013 Health Module Appeal Form and submitted by fax to the number on the Form by 4:30 pm EDT August 2, 2013. All of the Appeal Forms can be found on www.welcometouhc.com/shbp or on www.myuhc.com starting July 1, 2013. Please submit the proper form along with the required evidence of completion (which may include a copy of your screening results from a physician (if applicable), a Health Assessment completion statement, and/or an online module completion statement that shows date of completion). Complete Appeal Forms with attached evidence of completion will be processed within 30 business days of receipt, and your Personal Scorecard will be updated. If your Personal Scorecard is not updated within 30 business days of receipt of your Appeal Form, that is a determination that you did not complete the corresponding 2013 Wellness Requirements. You will be able to appeal this decision to SHBP in accordance with the Appeals section of this SPD.

IMPORTANT

The 2013 Physician Screening Form is available at www.welcometouhc.com/shbp and on www.myuhc.com. Please note that the online Personal Scorecard will always provide the most current points earned due to completion of your online Health Assessment, online module and biometric screening (if applicable). The UnitedHealth Personal Rewards online and paper Personal Scorecards encourage members to become more actively engaged in developing healthy behaviors as a way of life.

Personal Scorecard Instructions

Registering to view your UnitedHealth Personal Rewards online scorecard:

In order to benefit from the online Personal Scorecard, you must be registered to view your online UnitedHealth Personal Rewards scorecard. Simply go to uhcrewards.healthinsight.com/shbp and follow the directions on the website to register. Please be sure to register using the exact information displayed on your UnitedHealthcare Medical ID card.

A printed copy of your Personal Scorecard will be mailed to you once per year, even if you have not registered to view the online version.

If you would like additional information about the Personal Scorecard, please visit www.welcometouhc.com/shbp or call the toll-free number on the back of your UnitedHealthcare Medical ID card.

2014 Incentives and Wellness Requirements (does not apply to the MA PPO options)

You and your Spouse (if covered)will each be able to earn a $240 incentive fund contribution for 2014 by meeting the 2013 Wellness Requirements, as outlined above. Note: This incentive fund contribution may be used as long as you are enrolled in a 2014 SHBP Wellness or Standard Plan Option. In addition to the $240 incentive fund contributions, there may be additional incentives. To ensure you are eligible for all wellness-related incentives in 2014, you and your Spouse (if covered) must each meet the 2013 Wellness Requirements.

Examples for Group 1: (Member was enrolled in a 2012 Wellness Plan option and met the 2012 Wellness Promise)

A. Member and Covered Spouse both complete the 2013 Wellness Requirements:

— George (Member) completes his online Health Assessment on January 15th, 2013, and completes his online module on March 2, 2013. Martha (covered Spouse) completes her online Health Assessment on January 20th, 2013 and completes her online module on May 1, 2013.* $480 will be contributed to George and Martha's incentive fund in 2014. If an additional incentive is provided in 2014, George and Martha will be eligible for it because they both completed their 2013 Wellness Requirements.

*NEWLY ENROLLED SPOUSE: If Martha is a **newly enrolled** Spouse, she would also need to complete the biometric screening requirement. Example: Same as above and Martha completes a biometric screening through a physician's office on April 2, 2013, and the physician's office faxes the 2013 Physician Screening Form on April 14th, 2013. $480 will be contributed to George and Martha's incentive fund in 2014. If an additional incentive is provided in 2014, George and Martha will be eligible for it because they both completed their 2013 Wellness Requirements.

B. Member OR Covered Spouse (but not both) completes the 2013 Wellness Promise Requirements.

— Same as above, except that Martha does not complete her online module until June 15th (after the May 31st, 2013 deadline). $240 will be contributed to George and Martha's incentive fund in 2014. If an additional incentive is provided in 2014, George and Martha may not be eligible for it because only one of them completed the 2013 Wellness Requirements. For example, if there is a 2014 Wellness Plan Option, George may not be able to enroll in it.

C. Neither Member nor Covered Spouse completes the 2013 Wellness Requirements.

— Same as above, except that George also completes his online module after the deadline. They will not receive an incentive fund contribution in 2014. They may not be eligible for any other wellness incentive in 2014 because neither of them completed the 2013 Wellness Requirements.

Examples for Group 2: (Member was not enrolled in a 2012 Wellness Plan option)

A. Member and Covered Spouse both complete the 2013 Wellness Requirements:

— Dolly (Member) completes her online Health Assessment on January 15th, 2013, completes her online module on March 2, 2013, obtains the required biometric screening through a physician's office on April 2, 2013, and the physician's office faxes the 2013 Physician Screening Form on April 14th, 2013. James (covered Spouse) completes his online health assessment on January 15th, 2013, completes his online module on March 2nd, 2013, obtains the required biometric screening on April 10th, 2013, and the physician's office faxes the 2013 Physician Screening Form on April 14th, 2013. $480 will be contributed to Dolly and James' incentive fund in 2014. If an additional incentive is provided in 2014, Dolly and James may be eligible for it because they both completed their 2013 Wellness Requirements.

B. Member OR Covered Spouse (but not both) completes the 2013 Wellness Requirements.

— Same as above, except that James does not complete the online module until June 15th (after the May 31st, 2013 deadline). $240 will be contributed to James and Dolly's incentive fund in 2014. If an additional incentive is provided in 2014, Dolly and James may not be eligible for it because only one of them completed the 2013 Wellness Requirements.

C. Neither Member nor Covered Spouse completes the 2013 Wellness Requirements.

— Same as above, except that Dolly also does not complete the online module until June 15th (after the May 31st deadline). They will not receive an incentive fund contribution in 2014. They may not be eligible for any other wellness incentive in 2014 because neither of them completed the 2013 Wellness Requirements.

Section 1: What's Covered under this HRA Option --Benefits

The purpose of this Health Reimbursement Account Plan option is to pay costs of most medically necessary care and treatment of illness and accidental injury for Covered Persons after a deductible has been satisfied. Medical claims coded as Preventive Care and received from a Network provider are not subject to the deductible.

This section provides you with information about:

- Accessing Benefits. Refer to Section 1 "What's Covered—Benefits and Section 2 "What's Not Covered--Exclusions
- Your Health Reimbursement Account
- Coinsurance and Eligible Expenses.
- Annual Deductible, Out-of-Pocket Maximum and Maximum Plan Benefit.
- Lifetime limits on non-essential benefits.
- Covered Health Services. We pay Benefits for the Covered Health Services described in this section unless they are listed as not covered in Section 2: What's Not Covered--Exclusions.
- Covered Health Services that require you or your provider to obtain prior authorization from United Healthcare before you receive them. In general, Network providers are responsible for obtaining prior authorization from United Healthcare before they provide certain health services to you. You are responsible for obtaining prior authorization from United Healthcare before you receive certain health services from a non-Network provider.
- How this HRA Plan Option works
- Telephonic Tobacco Cessation Coaching Program.

Accessing Benefits

You can choose to receive either Network Benefits or Out-of-Network Benefits. To obtain Network Benefits you must see a Network Provider. After the applicable deductible has been satisfied, the Plan reimburses certain costs for Covered Health Services (Eligible Expenses) up to the Plan's allowed amounts. Note: Non-Covered Health Services are not eligible for reimbursement, regardless if the provider is Network or Out-of-Network.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under the Plan.

Benefits are available only if all of the following are true:

- Covered Health Services are received while the Plan is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in Section 9: Continuation of Coverage under COBRA occurs.
- Covered Health Services are received prior to the date your employer stops offering the Plan to you, either through termination of a contract with the Plan Administrator, cessation of the Plan for a category of employees, or by failing to pay required employer contributions or send required Member contributions.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Plan.

Depending on the geographic area and the service you receive, you may have access through UnitedHealthcare's Shared Savings Program to Non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, your Coinsurance is expressed as a percentage of Eligible Expenses for Out-of-Network Benefits, that percentage will remain the same as it is when you receive Covered Health Services from non-Network providers who have not agreed to discount their charges; however, the total that you owe may be less when you receive Covered Health Services from Shared Savings Program providers than from other Out-of-Network providers, who have not agreed to discount their charges; however, the Coinsurance percentage will be applied to the discounted charges, so the total you owe may be less when you receive Covered Health Services from Shared Savings Program providers.

Coinsurance

Coinsurance is the amount you pay each time you receive certain Covered Health Services. Please review the complete definition of Coinsurance in Section 11: Glossary of Defined Terms. Coinsurance amounts are listed on the following pages next to the description for each Covered Health Service. Coinsurance is a percentage of the cost of Eligible Expenses. If the Eligible Expenses are less than the billed charges for a Network Provider, you will not be responsible for paying the difference to the provider. If the Eligible Expenses are less than the billed charges for an Out-of-Network Provider, you will be responsible for paying the difference to the provider

HRA Plan Highlights

The Health Reimbursement Account (HRA) is a Consumer-Driven Health Plan Option (CDHP) that includes a SHBP funded health reimbursement account that provides first dollar coverage for eligible health care and pharmacy expenses.

The HRA is made up of three components:

1. An HRA funded by the SHBP and maintained by UnitedHealthcare;
2. A medical plan with a deductible and coinsurance and pharmacy benefits; and
3. Health information, tools and support

About Your Health Reimbursement Account

The amount placed in your HRA will depend upon the level of coverage you enroll for.

- If you elect tier coverage for Employee only, an annual amount of $500 will be placed in your HRA.
- If you elect tier coverage for You + Child(ren) or You + Spouse, an annual amount of $1,000 will be placed in your HRA
- If you elect coverage tier for You + Family, an annual amount of $1,500 will be placed in your HRA.
- If you are a new hire or newly enrolled in the HRA option within the Plan year, the funds in your HRA will be pro-rated monthly based on elected tier coverage.

The funds in your HRA are funded by the SHBP to help you pay a portion of your out-of-pocket costs under the medical plan, including annual deductibles and coinsurance.

*Employees and spouses enrolled in the HRA plan

If you do not use all of the funds in your HRA during the Plan year and you re-enroll in the UnitedHealthcare HRA or another HRA option offered by the SHBP for the following year, the balance remaining in your HRA will rollover. However, if you choose not to re-enroll in the UnitedHealthcare HRA or another HRA option offered by the SHBP during Open Enrollment or due to a Qualifying Event, you forfeit any balance remaining in your HRA, even if you re-enroll in a HRA option offered by the SHBP in a subsequent Plan year.

If your employment terminates for any reason the funds in your HRA will revert back to the SHBP, unless you elect COBRA coverage as described in this SPD. The HRA funds will remain available to assist you in paying your out-of-pocket costs under the medical plan while COBRA coverage is in effect.

If you experience a change in status during the Plan year that allows you to change your coverage tiers, any current balance in your HRA will remain unchanged; however, the amount placed in your HRA will change as follows:

- If you decrease your coverage tier (i.e., from You + Child(ren) or You + Family to You only), the amount placed in your HRA for that Plan year will not change.
- If you increase coverage tier, the additional amount placed in your HRA will increase. The increase will be pro-rated.

How the HRA Option Works

Your health plan requires you to meet an annual deductible before you are eligible for benefits under the Plan. This means that when you visit a provider, you are responsible for the costs associated with the visit until you meet your annual deductible. The money in your HRA can be used to help you satisfy some of the deductible. If there are HRA funds available after your deductible has been met, those funds can be used to reimburse you for coinsurance for covered health services.

If you receive services from a network provider, the provider will submit the bill to UnitedHealthcare for payment. Funds from your HRA can be used to pay for covered health services until the funds in the HRA are exhausted. If you choose, you may receive services from a non-network provider; however, you will be responsible for submitting a claim to UnitedHealthcare and requesting payment from the funds that remain available in your HRA.

If you deplete your HRA, you are responsible for payment of any costs incurred until you reach your annual deductible.

Once your annual deductible has been met for the year, covered health services are payable at a certain percentage of eligible expenses, as shown in the benefit information portion of this SPD.

To illustrate how this works, the following is an example of how your HRA fund can help lower some of your medical out-of-pocket expenses.

In the new Wellness Plan Option with family coverage, the money funded by SHBP can help cover the first $1,500 of your out-of-pocket expenses. This will lower your family deductible of $4,000 to $2,500. Once the remainder of the deductible has been satisfied, the Plan pays 85% of your in-network expenses or 60% of your out-of-network expenses until you reach your out-of-pocket maximum. Once your out-of-pocket maximum has been met, the Plan pays at 100%. Any unused dollars in your HRA roll over to the next Plan Year if you are still participating in this Option, but will be forfeited if you change options during the OE or due to a qualifying event.

One special benefit for enrolling in the Wellness HMO or Wellness HRA Plans is that certain drug costs are waived if SHBP is primary and you participate and remain compliant in one of the Disease State Management (DSM) Programs for Diabetes, Asthma and/or Coronary Artery Disease. Please remember if you enroll in this Plan after the 1st of the year, your HRA dollars are pro-rated but the deductibles are not.

NOTE: Prescription drug coinsurance does not apply to the deductible or maximum out-of-pocket limit. See the pharmacy section for additional information.

Requesting Reimbursement From Your HRA

You must submit a request for reimbursement of any medical expenses no later than March 31 following the end of the Plan year in which you are covered under this Plan. If you don't provide this information to us within this timeframe, your claim will not be eligible for reimbursement, even if there are funds available in your HRA. This time limit does not apply if you are legally incapacitated.

If You Receive Covered Health Services from a Network Provider

When you receive covered health services from a network provider, the funds in your HRA may be used to help you meet your annual deductible under your medical plan. Once the annual deductible is met, you are responsible for the difference between the amount of eligible expenses the medical plan pays and the total eligible expenses, including any coinsurance amounts. Any funds left in your HRA may be used to assist you in paying this difference.

Filing a Claim for Non-Network Benefits

If you have funds in your HRA and you receive health services from a non-network provider, you are responsible for filing a request for reimbursement. The request for claim reimbursement from your HRA funds may be made for claims incurred while you are considered a covered person under your medical plan.

If there are funds available in your HRA, they will be used to help meet your annual deductible under your medical plan. You are responsible for the difference between the amount charged by the non-network provider and the amount paid by your medical plan. .Any funds left in your HRA may be used to assist you in paying this difference.

Required Information for Filing a Non-Network Claim

When you request reimbursement from your HRA, you must complete the Health Reimbursement Account (HRA) claim form and attach itemized documentation as described on that form. The HRA claim form is available on myuhc.com or by calling the Customer Service telephone number on your ID card.

Eligible Expenses

Eligible Expenses for Covered Health Services, incurred while the Plan is in effect, are determined by us or by our designee. In almost all cases our designee is UnitedHealthcare. For a complete definition of Eligible Expenses that describes how payment is determined, see Section 11: Glossary of Defined Terms.

We have delegated to UnitedHealthcare the discretion and authority to determine on our behalf whether a treatment or supply is a Covered Health Service and how the Eligible Expense will be determined and otherwise covered under the Plan.

When you receive Covered Health Services from Network Providers, you are not responsible for any difference between the Eligible Expenses and the amount the provider bills. When you receive Covered Health Services from Non-Network Providers, you are responsible for paying, directly to the Non-Network Provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses.

The Plan Administrator and Claims Administrator do not have the legal authority to intervene when Out-of-Network Providers balance bill you. As a result, we cannot reduce or eliminate amounts balance billed. The SHBP cannot make additional payments above the allowed amounts when you are balance billed by Out-of-Network Providers.

Prior Authorization Requirements

Prior authorization is required before you receive certain Covered Health Services. In general, Network Providers are responsible for obtaining prior authorization from UnitedHealthcare before they provide these services to you. There are some Network Benefits, however, for which you are responsible for obtaining prior authorization from UnitedHealthcare. Failure to obtain prior authorization will result in a penalty.

Services for which you must provide prior authorization appear in this section under the *Must You Obtain Prior Authorization?* column in the table labeled Benefit Information.

To obtain prior authorization from United Healthcare by contacting Care Coordination call 1-800-955-7976. This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

When you choose to receive certain Covered Health Services from Non-Network providers, you are responsible for obtaining prior authorization from UnitedHealthcare before you receive these Covered Health Services. Failure to obtain prior authorization will result in a penalty equal to 50% of the Eligible Expenses.

When you choose to receive services from Non-Network providers, we urge you to confirm with UnitedHealthcare that the services you plan to receive are Covered Health Services, even if not indicated in the *Must You Obtain Prior Authorization?* column. That's because in

some instances, certain procedures may not meet the definition of a Covered Health Service and therefore, are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions such as:

- The Cosmetic Procedures exclusion. Examples of procedures that may or may not be considered Cosmetic include: breast reduction and reconstruction (except for after cancer surgery when it is always considered a Covered Health Service); vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty.
- The Experimental, Investigational or Unproven Services exclusion.
- Any other limitation or exclusion of the Plan.

To obtain prior authorization from United Healthcare by contacting Care Coordination call 1-800-955-7976.

Special Note Regarding Medicare

Prior authorization is required for transplant services, Skilled Nursing admissions and home intravenous medication therapy, even if Medicare is primary, and for expenses that Medicare does not cover. You should call Mental Health/Substance Use Disorder Administrator whenever you need mental health and substance abuse care, even if you have primary coverage through Medicare or a health plan other than SHBP.

Members Must Call Care Coordination at 1-800-955-7976 for Prior Authorization on the following services to be performed by Out-of-Network Providers

The services that require prior authorization are:

- **BRCA testing (breast cancer susceptibility)**
- **Non-emergent ambulance**
- **Clinical Trials**
- **CHD Surgeries**
- **Accidental Dental**
- **Durable Medical Equipment (DME) – greater than $1000), including insulin pumps**
- **Home Health Care**
- **Hospice – inpatient**
- **Hospital – inpatient**
- **MH/SU – inpatient & outpatient**
- **Maternity - IP stays that exceed normal 48 for vaginal delivery or >96 hours for cesarean**
- **Pregnancy – Healthy Pregnancy Notification Program**
- **Reconstructive Procedures**
- **Rehab Services (outpatient) – chiropractic**

- **SNF/Acute Rehab**
- **Surgery (outpatient) – diagnostic catheterization, electrophysiology implant, sleep apnea surgeries**
- **Therapeutics (outpatient) – dialysis, intensity modulated radiation therapy, MR-guided focused ultrasound**
- **Transplant Services**

A Non-prior authorization penalty of 50% of Eligible Expenses will apply to Covered Out-of-Network Services listed above and is the Member's Responsibility. For example, if billed charges are $150 and eligible expenses are $130, the 50% penalty will apply to the $130. The amount reimbursed at the 60% will be $65. The balance billed amount of $20, penalty of $65, and 40% ($26) which is member's coinsurance amount will be the Member's Responsibility. A Non-prior authorization penalty does not apply to the Out-of-Pocket maximum.

DISCLAIMER: The listing above requires that Care Coordination be notified. Members must obtain prior authorization from Care Coordination for Out-of-Network services. Read your SPD carefully regarding Covered Services. If you are in doubt about whether a service is covered and requires prior authorization, please call Customer Service at 1-877-246-4189. It is your responsibility to notify UHC of certain services and obtain prior authorization. Non-prior authorization could result in reduction in payment or non-payment. Prior authorization does not guarantee eligibility or payment.

For Non-Network Benefits, you should notify Care Coordination as soon as is reasonably possible if you are admitted to a Hospital as a result of an Emergency.

For Hospital - Inpatient Stay, you must obtain prior authorization from Care Coordination for elective admissions five business days before admission or as soon as reasonably possible and that you must notify Care Coordination for non-elective admissions (or admissions resulting from an Emergency): as soon as is reasonably possible.

For Inpatient Rehabilitation Facility Services and Skilled Nursing Facility, you must obtain prior authorization from Care Coordination for elective admissions five business days before admission and that you must notify Care Coordination for non-elective admissions (or admissions resulting from an Emergency) as soon as is reasonably possible.

Payment Information

Payment Term	Description	Amounts
Annual Deductible	The amount you pay for Covered Health Services before you are eligible to receive Benefits. For a complete definition of Annual Deductible, see Section 11: Glossary of Defined Terms. The actual amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Prescription drug coinsurance does not apply to the annual deductible. **Note**: The maximum amount an individual can apply to the You, You + Spouse, You + Child(ren) or You + Family deductible is the You deductible amount. The deductible may be satisfied cumulatively.	***Network and Non-Network (Before HRA Credit)*** You Deductible-$1,600 You + Spouse Deductible -$2,800 You + Child(ren) Deductible -$2,800 You Family Deductible-$4,000 *HRA Credit will reduce the Annual Deductible amounts *Pro-ration does not apply to the Annual Deductible *The deductible amount any one person can satisfy cannot be more than the You deductible. Once met, claims are reimbursed according to plan guidelines for that individual.

Payment Term	Description	Amounts
Out-of-Pocket Maximum	The maximum you pay for Covered Health Services, out of your pocket, in a Plan year for Coinsurance. For a complete definition of Out-of-Pocket Maximum, see Section 11: Glossary of Defined Terms. Prescription drug coinsurance does not apply to the maximum out-of-pocket. The Out-of-Pocket maximum does include the Annual Deductible.	***Network and Non-Network*** You Out-of-Pocket -$4,000 You + Spouse Out-of-Pocket -$6,500 You + Child(ren) Out-of-Pocket - $6,500 You + Family Out-of-Pocket -$9,000 *HRA Credit will reduce the Out-of-Pocket amounts *Pro-ration does not apply to the Out-of-Pocket
	Note: The maximum amount an individual can apply to the You, You + Spouse, You + Child(ren) or You + Family out-of-pocket amount is the You amount.	*The out-of-pocket amount an individual can meet cannot be more than the You out-of-pocket amount. Once met, claims are reimbursed at 100% of eligible expenses for that individual. The out-of-pocket can be met cumulatively

Payment Term	Description	Amounts
HRA Credit	The amount funded by the SHBP to help you pay a portion of your first dollar Out-of-Pocket costs for Covered Health Services under the medical plan.	***Network and Non-Network (After HRA Credit)*** You HRA Credit-$500 You + Spouse HRA Credit-$1,000 You + Child(ren) HRA Credit-$1,000 You + Family HRA Credit-$1,500 *HRA credits may be subject to Pro-ration * HRA credit dollars are available on a first come first service basis. One individual can exhaust all HRA credit dollars.

Payment Term	Description	Amounts
Lifetime Maximum* There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan	*Generally the following are considered to be essential benefits under the Patient Protection and Affordable Care Act: Ambulatory patient services; emergency services, hospitalization; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.	Unlimited

Benefit Information

Description of Covered Health Service	Must You Obtain Prior Authorization?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
1. Ambulance Services - Emergency only Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed. Non-emergency transportation ground or air transportation of Covered Person to or from a medical facility, Physician's office, or patient's home is excluded, unless approved by Care Coordination. **Note**: Emergency, life threatening, medically necessary ambulance transportation is available to the CLOSEST facility able to treat the condition, even if you are out of the country. If you are traveling outside the U.S. and wish to be transported back into the U.S. for treatment, you may want to consider purchasing travel insurance. If the services are provided at a facility that is not the closest facility able to treat the condition, the SHBP will not assume financial responsibility for the additional transportation charges.	***Network*** N/A	*Ground Transportation:* 15% *Air Transportation:* 15%	Yes	Yes
	Out-of-Network N/A	**Same As Network**		

Description of Covered Health Service	Must You Obtain Prior Authorization?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?

2. Dental Services and Oral Care Surgery:

Prior Authorization

You must obtain prior authorization from United Healthcare by contacting Care Coordination as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. You do not have to obtain authorization before the initial Emergency treatment. When you obtain authorization, United Healthcare can determine whether the service is a Covered Health Service. If authorization from United Healthcare is not obtained a Non-prior authorization penalty equal to 50% of Eligible Expenses will be applied. Non-prior authorization penalties are never applied to deductibles or Out-of-Pocket Maximums.

A. Accident only Dental services when all of the following are true: • Treatment is necessary because of accidental damage. • Dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D.". The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident.	***Network*** Yes	15%	Yes	Yes
	Out-of-Network Yes	40%	Yes	Yes

(Benefit information continued on the next page)

Description of Covered Health Service	Must You Obtain Prior Authorization?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was: • A sound and natural or unrestored tooth, or • A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech. Dental services for final treatment to repair the damage must be both of the following: • Started within three months of the accident. • Completed within 36 months of the accident. **Note**: Dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities.				

(Benefit information continued on the next page)

Description of Covered Health Service	Must You Obtain Prior Authorization?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
B. Oral Care The Plan will pay benefits only for: • Reconstructive surgical procedures (including dental implants and dentures) for the repair of sound, natural teeth or tissue that were damaged as a result of oral cancer or treatment for oral cancer such as chemotherapy or radiation treatment and other cancer related treatments with prior approval by Care Coordination, • Surgery to treat lesions of the mouth, lip or tongue, if the lesion requires a pathological examination, • Surgery (frenulectomy) for treatment of a child's speech impairment, when medically indicated, • Surgery of accessory sinuses, salivary glands or ducts, surgery to repair cleft palates, • Orthognathic surgery to correct obstructive sleep apnea and for dependents age 19 and under born with specific craniofacial syndromes, and as determined by Care Coordination policies, • Institutional and anesthesia charges associated with a non-covered dental care normally performed in a dental office, but due to the patient's medical condition, care in a Hospital setting is warranted, as required under State Law. (Benefit information continued on the next page)	***Network*** Yes ***Out-of-Network*** Yes	15% 40%	Yes Yes	Yes Yes

Description of Covered Health Service	Must You Obtain Prior Authorization?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Repairs that are not performed promptly (as defined) will be denied unless a compelling medical reason exists. X-Rays and other documentation may be required to determine benefit coverage.				
C. Temporomandibular Joint Dysfunction (TMJ) Covered Health Services for diagnostic and surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician. Benefits include necessary diagnostic or surgical treatment required as a result of accident, trauma, congenital defect, developmental defect, or pathology. Benefits are not available for charges or services that are dental in nature. Diagnostic testing or non-surgical therapy for TMJ dysfunction, subject to a lifetime benefit limit of $1,100 (x-rays not subject to maximum limit). Occlusal orthotic (splints) appliances to treat TMJ dysfunction, subject to a lifetime benefit limit of $500.	***Network*** Yes ***Out-of-Network*** Yes	15% 40%	Yes Yes	Yes Yes

Description of Covered Health Service	Must You Obtain Prior Authorization?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
3. Durable Medical Equipment **Prior Authorization** **You must obtain prior authorization from United Healthcare by contacting Care Coordination before obtaining any single item of Durable Medical Equipment that costs more than $1,000 (either purchase price or cumulative rental of a single item).** **For Out-of-Network Benefits you must obtain prior authorization from United Healthcare by contacting Care Coordination before obtaining any single item of DME that costs more than $1,000 (either purchase price or cumulative rental of a single item) or you will pay a Non-prior authorization penalty equal to 50% of Eligible Expenses. Non-prior authorization penalties are never applied to deductibles or out-of-pocket maximums.** Durable Medical Equipment (DME) that meets each of the following criteria: • Ordered or provided by a Physician for outpatient use. • Manufactured and used for medical purposes. • Not consumable or disposable, except urinary catheters and ostomy supplies. • Disposable items that are considered an integral part of covered DME (Benefit information continued on the next page)	***Network*** Yes ***Out-of-Network*** Yes, for items more than $1,000. Obtain prior authorization from UnitedHealthcare by contacting Care Coordination for items more than $1,000	15% 40%	Yes Yes	Yes Yes

Description of Covered Health Service	Must You Obtain Prior Authorization?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?

- Not of use to a person in the absence of a disease or disability.
- Compression stockings (limit two per Plan year).
- Diabetic shoes (limit one pair every 3 years).

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the most cost effective piece of equipment.

Benefits are provided for the replacement of a type of Durable Medical Equipment once every three calendar years.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a wheelchair or scooter
- A standard Hospital type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).

(Benefit information continued on the next page)

Description of Covered Health Service	Must You Obtain Prior Authorization?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage. • Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage). Wheelchairs are only covered every three years unless reviewed and approved by Care Management in instances when there has been a change in the member's health status. UnitedHealthcare will decide if the equipment should be purchased or rented. For maximum benefit, you may purchase or rent Durable Medical Equipment from a UnitedHealthcare vendor.				

Description of Covered Health Service	Must You Obtain Prior Authorization?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
4. Emergency Health Services Services that are required to stabilize or initiate treatment in an Emergency and are received on an outpatient basis at a Hospital or Alternate Facility. If admitted, refer to Hospital – Inpatient Stay benefits. For Non-Network Benefits, you should notify Care Coordination as soon as is reasonably possible if you are admitted to a Hospital as a result of an Emergency. You will find more information about Benefits for Emergency Health Services in Section 3: Description of Network and Out-of-Network Benefits.	***Network*** No ***Out-of-Network*** No	15% Same as Network	Yes Same as Network	Yes Same as Network
5. Eye Examinations ***A. Medical:*** Eye examinations received from a health care provider, for diagnosis and treatment of eye condition. **Note**: We will cover eyeglasses or contact lenses (first pair only) within 12 months of cataract surgery. Refer to DME benefits for eye hardware coverage. (Benefit information continued on the next page)	***Network*** No ***Out-of-Network*** No	15% 40%	Yes Yes	Yes Yes

Description of Covered Health Service	Must You Obtain Prior Authorization?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
B. Routine: Benefits include one routine vision exam, including refraction, to detect vision impairment by a Network Provider, limited to one every 24 months. Routine eye exams are not subject to the deductible. Vision Discount program available through United Health Wellness 1-800-860-8773.	***Network*** No	0%	No	No
	Out-of-Network	**Non-Network routine eye exams are not covered**.		
6. Hearing Services Hearing examinations, tests and fittings received from a health care provider. Hearing aid coverage is limited to $1,500 every 5 years. Amount exceeding $1,500 is member responsibility and does not apply to deductible or out-of-pocket maximum. Hearing aids are covered (with a prescription, or documentation of medical necessity or hearing loss) with a $1,500 benefit max every 5 years. However, telephonic/online hearing tests and evaluations are not covered and are listed as exclusions under the Exclusions section of this SPD.	***Network*** No	Hearing Exams, tests & fittings: 15%	Yes	Yes
		Hearing Aids: 0%	No	No
	Out-of-Network No	Hearing Exams, tests & fittings: 15%	Yes	Yes
		Hearing Aids: 0%	No	No

Description of Covered Health Service	Must You Obtain Prior Authorization?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
7. Home Health Care **Prior Authorization** **You must obtain prior authorization from United Healthcare by contacting Care Coordination for Home Health Care Services.** **For Out-of-Network benefits you must obtain prior authorization from UnitedHealthcare by contacting Care Coordination at least five business days before receiving Home Health Care Services or you will pay a non-prior authorization penalty equal to 50% of Eligible Expenses. Non-prior authorization penalties are never applied to deductibles or out-of-pocket maximums.** Services received from a Home Health Agency that are both of the following: • Ordered by a Physician. • Provided by or supervised by a registered nurse in your home. Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled care is required. (Benefit information continued on the next page)	***Network*** Yes ***Out-of-Network*** Yes Obtain prior authorization from UnitedHealthcare by contacting Care Coordination	15% 40%	Yes Yes	Yes Yes

Description of Covered Health Service	Must You Obtain Prior Authorization?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true: • It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient. • It is ordered by a Physician. • It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair. • It requires clinical training in order to be delivered safely and effectively. • It is not Custodial Care. UnitedHealthcare will decide if skilled care is required by reviewing both the skilled nature of the service and the need for Physician directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver. UnitedHealthcare will approve a certain number of visits. Benefits will only be paid for approved visits. One visit equals four consecutive hours in a 24 hour period.				

Description of Covered Health Service	Must You Obtain Prior Authorization?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
8. Hospice Care **Prior Authorization** **You must obtain prior authorization from UnitedHealthcare by contacting Care Coordination for Hospice Care.** **For Out-of-Network Benefits you must obtain prior authorization from United Healthcare by contacting Care Coordination within one business day or on the same day of admission if reasonably possible. If you don't obtain prior authorization from United Healthcare by contacting Care Coordination, you will pay a non-prior authorization penalty equal to 50% of Eligible Expenses. Non-prior authorization penalties are never applied to deductibles or out-of-pocket maximums.** Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person, and short term grief counseling for immediate family members. Benefits are available when hospice care is received from a licensed hospice agency. Please contact UnitedHealthcare for more information regarding guidelines for hospice care. You can contact UnitedHealthcare at the telephone number on your ID card.	***Network*** Yes ***Out-of-Network*** Yes Obtain prior authorization from UnitedHealthcare by contacting Care Coordination	15% 40%	Yes Yes	Yes Yes

Description of Covered Health Service	Must You Obtain Prior Authorization?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
9. Hospital - Inpatient Stay	***Network***			
Prior Authorization **For Hospital - Inpatient Stay, you must obtain prior authorization from Care Coordination for elective admissions five business days before admission or as soon as reasonably possible and that you must notify Care Coordination for non-elective admissions (or admissions resulting from an Emergency): as soon as is reasonably possible. If you don't obtain prior authorization from United Healthcare by contacting Care Coordination for Non-Network prior authorization requirements above, you will pay a non-prior authorization penalty equal to 50% of Eligible Expenses. Non-prior authorization penalties are never applied to deductibles or out-of-pocket maximums.**	Yes	15%	Yes	Yes
		Wellness Newborn Care Facility: 15%	Yes	Yes
	Out-of-Network Yes	40%	Yes	Yes
	Obtain prior authorization from UnitedHealthcare by contacting Care Coordination	Wellness Newborn Care other than Preventive Care: 40%	Yes	Yes

(Benefit information continued on the next page)

Description of Covered Health Service	Must You Obtain Prior Authorization?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Inpatient Stay in a Hospital. Benefits are available for: • Supplies and non-Physician services received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds). Benefits for Physician services are described under *Professional Fees for Surgical and Medical Services.*				
10. Infertility Services We will cover diagnostic testing to rule out a diagnosis, but once diagnosed treatment of infertility is not covered. Coverage for Infertility drugs may be approved for a medical diagnosis not related to infertility treatment if the medical diagnosis meets the definition of a Covered Health Service and is not an Experimental, Investigational, or Unproven Service. UnitedHealthcare must be contacted by your physician to determine coverage. Please also refer to Section 2: What's Not Covered -- Exclusions under item L. Reproduction.	***Network*** No ***Out-of-Network*** No	15% 40%	Yes Yes	Yes Yes

Description of Covered Health Service	Must You Obtain Prior Authorization?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
11. Injections Benefits are available for injections received in a Physician's office when no other health service is received, for example allergy immunotherapy.	***Network*** No	15% per injection	Yes	Yes
	Out-of-Network No	40% per injection	Yes	Yes
12. Inpatient Rehabilitation Facility Services **Prior Authorization** **Please remember that for Inpatient Rehabilitation Facility Services, you must obtain prior authorization from Care Coordination for elective admissions five business days before admission and that you must notify Care Coordination for non-elective admissions (or admissions resulting from an Emergency) as soon as is reasonably possible.** Services for an Inpatient Stay in an Inpatient Rehabilitation Facility. Benefits are available for: • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds). (Benefit information continued on the next page)	***Network*** Yes	15%	Yes	Yes
	Out-of--Network Yes	40%	Yes	Yes

Description of Covered Health Service	Must You Obtain Prior Authorization?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Please note that Benefits are available only for the care and treatment of an Injury or Sickness that would have otherwise required an Inpatient Stay in a Hospital.				
13. Maternity (Physician Services for prenatal, delivery and postpartum) **Prior Authorization** **You must obtain prior authorization from UnitedHealthcare by contacting Care Coordination for Maternity. For Out-of-Network Benefits you must obtain prior authorization from United Healthcare by contacting Care Coordination as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than the time frames described below. If you don't notify United HealthCare that the Inpatient Stay will be extended, you will pay a non-prior authorization penalty equal to 50% of Eligible Expenses. Non-prior authorization penalties are never applied to deductibles or out-of-pocket maximums.** Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity related medical services for prenatal care, postnatal care, delivery, and any related complications. (Benefit information continued on the next page)	***Network*** Yes ***Out-of-Network*** *Yes, if Inpatient Stay exceeds time frames.	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, and Outpatient Diagnostic and Therapeutic Services. Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services.		

Description of Covered Health Service	Must You Obtain Prior Authorization?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
There are special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should obtain prior authorization from UnitedHealthcare during the first trimester, but no later than one month prior to the anticipated delivery date. Benefits for an Inpatient Stay : • **According to Federally Mandated Guidelines we will pay 48** hours for the mother and newborn child following a normal vaginal delivery. • *** According to Federally Mandated Guidelines we will pay** 96 hours for the mother and newborn child following a cesarean section delivery. If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames. Note: The listed Benefits for newborn child apply only if the newborn child is added to the Plan within 90 days of birth and premiums are paid from the month of birth.				

Description of Covered Health Service	Must You Obtain Prior Authorization?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
14. Mental Health Services **Prior Authorization** **You must call the Mental Health / Substance Use Disorder Designee at UnitedHealthcare to obtain prior authorizations to receive these Benefits in advance of any treatment. The Mental Health/Substance Use Disorder Designee phone number that appears on your ID card is 1-877-702-6342. Must receive prior authorization through the Mental Health/Substance Abuse Designee. There is a 50% penalty for Out of Network providers if authorization is not received. There is a 100% penalty for Network providers without authorization. Authorization is required for international providers. There is no authorization required for MD/APRN for Network and Out-of-Network and neuropsychiatric testing.** Mental Health Services include those received on an inpatient or Intermediate Care basis in a Hospital or Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility. Benefits for Mental Health Services include: • Mental health evaluations and assessment. • Diagnosis. (Benefit information continued on the next page)	***Network*** Yes You must call the Mental Health / Substance Use Disorder Designee at UnitedHealthcare to receive the Benefits.	Hospital-Inpatient Stay 15% per Inpatient Stay Physician's Office/ Alternate Facility Services 15%	Yes Yes	Yes Yes
	Out-of-Network Yes You must call the Mental Health / Substance Use Disorder Designee at UnitedHealthcare to receive the Benefits.	Hospital-Inpatient Stay 40% per Inpatient Stay Physician's Office/ Alternate Facility Services 40%	Yes Yes	Yes Yes

Description of Covered Health Service	Must You Obtain Prior Authorization?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• Treatment planning. • Referral services. • Medication management. • Psychological testing to rule out any diagnosis • Inpatient services. • Partial hospitalization/day treatment. • Intensive outpatient treatment. • Individual, family and group therapeutic services. • Crisis intervention. Emergencies are paid based on the plan guidelines. Non-emergency services are not covered. The Mental Health/Substance Use Disorder Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. Referrals to a Mental Health provider are at the sole discretion of the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating all of your care. Mental Health Services must be authorized and overseen by the Mental Health/Substance Use Disorder Designee. Contact the Mental Health/Substance Use Disorder Designee regarding Benefits for Mental Health Services. (Benefit information continued on the next page)				

Description of Covered Health Service	Must You Obtain Prior Authorization?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Special Mental Health Programs and Services Special programs and services that are contracted under the Mental Health/Substance Use Disorder Designee may become available to you as part of your Substance Use Disorder Services benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, Outpatient Care category of benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Substance Use Disorder which may not otherwise be covered under this Plan. You must be referred to such programs through the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.				

Description of Covered Health Service	Must You Obtain Prior Authorization?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
15. Nutritional Counseling/Childhood Obesity Covered Health Services provided by an approved provider such as a registered or licensed dietician/ nutritionist in an individual or group session for Covered Persons with medical conditions that require a special diet. Examples of such medical conditions include, but are not limited to: • Diabetes mellitus. • Coronary artery disease. • Congestive heart failure. • Severe obstructive airway disease. • Gout. • Renal failure. • Phenylketonuria. • Hyperlipidemias. • Eating Disorders.	***Network*** No	0%	No	No
	Out-of-Network No	0%	No	No

(Benefit information continued on the next page)

Description of Covered Health Service	Must You Obtain Prior Authorization?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Benefits are limited to three individual sessions during a Covered Person's lifetime for each medical condition except for childhood obesity. Note: Does not require enrollment in Disease Management Program through Care Coordination.				
Childhood Obesity For ages 3-18 with a 4 visit limitation per plan year for physicians and 4 visit limitation per plan year for Registered Dietitians who qualify as determined by their physician.	***Network*** No	15%	Yes	Yes
	Out-of-Network No	40%	Yes	Yes

Description of Covered Health Service	Must You Obtain Prior Authorization?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
16. Ostomy and Urinary Catheter Supplies **Prior Authorization** **You must obtain prior authorization from United Healthcare by contacting Care Coordination before obtaining any single item of Durable Medical Equipment that costs more than $1,000 (either purchase price or cumulative rental of a single item).** **For Out-of-Network Benefits you must obtain prior authorization from United Healthcare by contacting Care Coordination before obtaining any single item of DME that costs more than $1,000 (either purchase price or cumulative rental of a single item) or you will pay a Non-prior authorization penalty equal to 50% of Eligible Expenses. Non-prior authorization penalties are never applied to deductibles or out-of-pocket maximums.** Benefits for ostomy supplies include only the following: • Pouches, face plates and belts. • Irrigation sleeves, bags and catheters. • Skin barriers. • Urinary Catheters. Benefits are not available for gauze, adhesive, adhesive remover, deodorant, pouch covers, or other items not listed above.	***Network*** Yes ***Out-of-Network*** Yes, for items more than $1,000. Obtain prior authorization from UnitedHealthcare by contacting Care Coordination for items more than $1,000	15% 40%	Yes Yes	Yes Yes

Description of Covered Health Service	Must You Obtain Prior Authorization?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?

17. Outpatient Surgery, Diagnostic and Therapeutic Services

Prior Authorization

You must obtain prior authorization from UnitedHealthcare by contacting Care Coordination for diagnostic catheterization, electrophysiology implant and sleep apnea surgeries five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible.

You must obtain prior authorization from UnitedHealthcare by contacting Care Coordination five business days before scheduled dialysis services are received and for intensity modulated radiation therapy and MR-guided focused ultrasounds or, for non-scheduled services, within one business day or as soon as reasonably possible.

If you don't obtain prior authorization from United Healthcare by contacting Care Coordination for Network or Non-Network notification requirements above, you will pay a non-prior authorization penalty equal to 50% of Eligible Expenses. Non-prior authorization penalties are never applied to deductibles or out-of-pocket maximums.

(Benefit information continued on the next page)

Description of Covered Health Service	Must You Obtain Prior Authorization?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
A. Outpatient Surgery Covered Health Services for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility. Benefits under this section include only the facility charge and the charge for supplies and equipment. Benefits for the surgeon fees related to outpatient surgery are described under *Professional Fees for Surgical and Medical Services*. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services*.	***Network*** Yes ***Out-of-Network*** Yes	15% 40%	Yes Yes	Yes Yes
B. Outpatient Diagnostic/Therapeutic Services Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including: • CT scans • PET scans • MRI • Nuclear Medicine When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services*.	***Network*** Yes ***Non-Network*** Yes	15% 40%	Yes Yes	Yes Yes

Description of Covered Health Service	Must You Obtain Prior Authorization?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
18. Physician's Office Services				
A. Medical **Covered Health Services other than Preventive Care, such as for the diagnosis and treatment of a Sickness or Injury received in a Physician's office.**	***Network*** No	15%	Yes	Yes
X-Rays/lab services are subject to the deductible	***Out-of-Network*** No	40%	Yes	Yes
The treatment of childhood obesity is a covered benefit for eligible members. This benefit is limited to 4 visits with primary care physician and 4 visits with a registered dietician per calendar year. Refer to Nutritional Counseling section for registered dietician guidelines.	***Network*** No	15%	Yes	Yes
	Out-of-Network No	40%	Yes	Yes
B. Preventive Care: **For a complete listing of covered Preventive Care, see the definition of Preventive Care in the Glossary.** Preventive services must be billed with appropriate preventive service codes.	***Network*** No	0%	N/A	No
	Out-of--Network	**There are No Benefits for Out-of Network Preventive Care.**		

Description of Covered Health Service	Must You Obtain Prior Authorization?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
19. Professional Fees for Surgical and Medical Services Professional fees for surgical procedures and other medical care received in a Hospital, Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* above.	***Network*** Yes	15%	Yes	Yes
	Out-of-Network Yes	40%	Yes	Yes
20. Prosthetic Devices **Prior Authorization** **You must obtain prior authorization from United Healthcare by contacting Care Coordination for Prosthetic Devices.** **For Out-of-Network Benefits you must obtain prior authorization from United Healthcare by contacting Care Coordination five business days before receiving a Prosthetic Device or you will pay a non-prior authorization penalty equal to 50% of Eligible Expenses. Non-prior authorization penalties are never applied to deductibles or out-of-pocket maximums.**	***Network*** Yes	15%	Yes	Yes
	Out-of-Network Yes Notify UnitedHealthcare by contacting Care Coordination	40%	Yes	Yes

(Benefit information continued on the next page)

Description of Covered Health Service	Must You Obtain Prior Authorization?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
External prosthetic devices that replace a limb or an external body part, limited to: • Artificial arms, legs, feet and hands. • Artificial eyes, ears and noses. • Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm, quantity limits apply. Cochlear implants are covered but are subject to Prior Authorization. If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost effective prosthetic device that brings the member to closest baseline functionality. Except for items required by the Women's Health and Cancer Rights Act of 1998, any combination of Network and Out-of-Network Benefits for non-essential prosthetic devices is limited to $50,000 per Plan year. This limit applies to the total amount that we will pay for prosthetic devices and does not include any Coinsurance or Annual Deductible responsibility you may have. **Note**: Replacement may be covered after 2 - 3 years in accordance with UnitedHealthcare clinical guidelines. (Benefit information continued on the next page)				

Description of Covered Health Service	Must You Obtain Prior Authorization?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
While the plan provides coverage for an upper extremity prosthesis, benefits are limited to the most cost-effective device that restores baseline functionality. **Note**: This is a Plan benefit interpretation only, based on available clinical information and current Plan language, and is not intended to influence decisions regarding ongoing medical care.				
21. Reconstructive Procedures **Prior Authorization** **You must obtain prior authorization from United Healthcare by contacting Care Coordination for Reconstructive Procedures.** **For Out-of-Network Benefits you must obtain prior authorization from United Healthcare by contacting Care Coordination five business days before receiving Reconstructive Procedures or you will pay a non-prior authorization penalty equal to 50% of Eligible Expenses. Non-prior authorization penalties are never applied to deductibles or out-of-pocket maximums. When you provide prior authorization, Care Coordination can verify that the service is a reconstructive procedure rather than a Cosmetic Procedure. Cosmetic Procedures are always excluded from coverage.** (Benefit information continued on the next page)	***Network*** Yes ***Out-of-Network*** Yes Obtain prior authorization from UnitedHealthcare by contacting Care Coordination	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices. Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices.		

Description of Covered Health Service	Must You Obtain Prior Authorization?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Services for reconstructive procedures, when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The fact that physical appearance may change or improve as a result of a reconstructive procedure does not classify such surgery as a Cosmetic Procedure when a physical impairment exists, and the surgery restores or improves function. Cosmetic Services are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. **NOTE:** Breast reductions may or may not be considered cosmetic, therefore, breast reduction treatment is subject to prior approval. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure. (Benefit information continued on next page)				

Description of Covered Health Service	Must You Obtain Prior Authorization?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Note: Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact UnitedHealthcare at the telephone number on your ID card for more information about Benefits for mastectomy related services.				
22. Rehabilitation Services - Outpatient Therapy **Prior Authorization** **You must obtain prior authorization from United Healthcare by contacting Care Coordination for Physical therapy benefits extending beyond the 40 visits for children up to age 19 with Congenital Anomalies that require surgical correction. For Out-of-Network Benefits you must obtain prior authorization from United Healthcare by contacting Care Coordination five business days before receiving Physical therapy. Without prior authorization, you will be responsible for paying all charges and no Benefits will be paid.**	***Network*** Yes, as noted for physical therapy	15%	Yes	Yes
	Out-of-Network Yes, as noted for physical therapy	40%	Yes	Yes

(Benefit information continued on the next page)

Description of Covered Health Service	Must You Obtain Prior Authorization?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Short-term outpatient rehabilitation services for: • Physical therapy*. (40 visits per Plan year) • Occupational therapy. (40 visits per Plan year) • Speech therapy (40 visits per Plan year) • Pulmonary rehabilitation therapy. (40 visits per Plan year) • Cardiac rehabilitation therapy. (40 visits per Plan year) *Physical Therapy benefits may be extended beyond 40 visits for children up to age 19 with Congenital Anomalies that require surgical correction. The child will also have to be in case management See Prior Authorization requirements above. Any combination of Network and Out-of-Network Benefits for any one type of Rehabilitation Services is limited to 40 visits per therapy per Plan year. Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician. Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your condition within two months of the start of treatment.				

Description of Covered Health Service	Must You Obtain Prior Authorization?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
23. Skilled Nursing Facility **Prior Authorization** **You must obtain prior authorization from Care Coordination for elective admissions five business days before admission and that you must notify Care Coordination for non-elective admissions (or admissions resulting from an Emergency) as soon as is reasonably possible.** Services for an Inpatient Stay in a Skilled Nursing Facility. Benefits are available for: • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds). Network Benefits are limited to 120 days per Plan year. **Note**: Benefits are available only for the care and treatment of an Injury or Sickness that would have otherwise required an Inpatient Stay in a Hospital.	***Network*** Yes	15%	Yes	Yes
	Out-of-Network **There Are No Benefits Available For Out-of-Network Skilled Nursing Facility**			

Description of Covered Health Service	Must You Obtain Prior Authorization?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
24. Spinal Treatment, Chiropractic and Osteopathic Manipulative Therapy **Prior Authorization** **You must obtain prior authorization from United Healthcare by contacting Care Coordination for Spinal Treatment, Chiropractic and Osteopathic Manipulative Therapy.** **For Out-of-Network Benefits you must obtain prior authorization from United Healthcare by contacting Care Coordination before receiving Spinal Treatment, Chiropractic and Osteopathic Manipulative Therapy or you will pay a non-prior authorization penalty equal to 50% of Eligible Expenses. Non-prior authorization penalties are never applied to deductibles or out-of-pocket maximums.** Benefits for Spinal Treatment when provided by a Spinal Treatment provider in the provider's office. Benefits include diagnosis and related services and are limited to one visit and treatment per day. Any combination of Network and Out-of-Network Benefits for Spinal Treatment is limited to 20 visits per Plan year.	***Network*** Yes ***Out-of-Network*** Yes Obtain prior authorization from UnitedHealthcare by contacting Care Coordination	15% 40%	Yes Yes	Yes Yes

Description of Covered Health Service	Must You Obtain Prior Authorization?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
25. Substance Use Disorder Services **Prior Authorization** **Referrals to a Substance Use Disorder provider are at the sole discretion of the Mental Health/Substance Use Disorder Designee at UnitedHealthcare, who is responsible for coordinating all of your care. Substance Use Disorder Services must be authorized and overseen by the Mental Health/Substance Use Disorder Designee. Contact the Mental Health/Substance Use Disorder Designee regarding Benefits for Substance Use Disorder Services.** **You must call the Mental Health/Substance Use Disorder Designee at UnitedHealthcare and to obtain prior authorization to receive these Benefits in advance of any treatment. The Mental Health/Substance Use Disorder Designee phone number that appears on your ID card is 1-877-702-6342. Must receive prior authorization through the Mental Health/Substance Abuse Designee. There is a 50% penalty for Out of Network providers if authorization is not received. There is a 100% penalty for Network providers without authorization. Authorization is required for international providers. There is no authorization required for MD/APRN for Network and Out-of-Network and neuropsychiatric testing.** (Benefit information continued on the next page)	***Network*** Yes You must call the Mental Health / Substance Use Disorder Designee at UnitedHealthcare for prior authorization to receive the Benefits.	***Hospital-Inpatient Stay*** 15% per Inpatient Stay ***Physician's Office/ Alternate Facility Services*** 15%	Yes Yes	Yes Yes

Description of Covered Health Service	Must You Obtain Prior Authorization?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Substance Use Disorder Services include those received on an inpatient or Intermediate Care basis in a Hospital or an Alternate Facility and those received on an outpatient basis in a provider's office or at an Alternate Facility. Benefits for Substance Use Disorder Services are only provided if authorized by the Mental Health/Substance Use Disorder Designee. Benefits include: • Substance Use Disorder or chemical dependency evaluations and assessment; • Diagnosis; • Treatment planning; • Detoxification (sub-acute/non-medical); • Inpatient services; • Partial Hospitalization/Day Treatment; • Intensive Outpatient Treatment; • Referral services; • Medication management; • Psychological testing to rule out any diagnosis • Individual, family and group therapeutic services; and • Crisis intervention. (Benefit information continued on the next page)	***Out-of-Network*** Yes You must call the Mental Health / Substance Use Disorder Designee at UnitedHealthcare for prior authorization to receive the Benefits.	***Hospital-Inpatient Stay*** 40% per Inpatient Stay ***Physician's Office/ Alternate Facility Services*** 40%	Yes Yes	Yes Yes

Description of Covered Health Service	Must You Obtain Prior Authorization?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Emergencies are paid based on plan guidelines. Non-emergency services are not covered. The Mental Health/Substance Use Disorder Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. **Special Substance Use Disorder Programs and Services** Special programs and services that are contracted under the Mental Health/Substance Use Disorder Designee may become available to you as part of your Substance Use Disorder Services benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment and Outpatient Care category of benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Substance Use Disorder which may not otherwise be covered under this Plan. You must be referred to such programs through the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.				

Description of Covered Health Service	Must You Obtain Prior Authorization?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
26. Transplantation Services **Prior Authorization** **You must obtain prior authorization from United Healthcare by contacting Care Coordination at 1-800-955-7976, as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you do not obtain prior authorization and if the transplantation services are not performed at a Designated Facility, you will be responsible for paying all charges and Benefits will not be paid.** Covered Health Services for the following organ and tissue transplants when ordered by a Physician. For Network Benefits, transplantation services must be received at a Designated Facility. Benefits are available for the transplants listed below when the transplant meets the definition of a Covered Health Service, and is not an Experimental, Investigational or Unproven Service. (Benefit information continued on the next page)	***Network*** Yes Obtain prior authorization from UnitedHealthcare by contacting Care Coordination ***Out-of-Network*** **There Are No Benefits Available For Out-of-Network Designated Transplant Facilities**	15% if a Network designated transplant facility is used.	Yes	Yes

Description of Covered Health Service	Must You Obtain Prior Authorization?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
The Coinsurance and Annual Deductible will not apply to Network Benefits when a transplant listed below is received at a Designated Facility. The services described under **Transportation and Lodging** below are Covered Health Services **ONLY** in connection with a transplant received at a Designated Facility. • Bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service. The search for bone marrow/stem cell from a donor who is not biologically related to the patient is a Covered Health Service only for a transplant received at a Designated Facility. • Cornea transplants (Network Benefits are also available for cornea transplants that are provided by a Network Physician at a Network Hospital. We do not require that cornea transplants be performed at a Designated Facility in order for you to receive Network Benefits. For cornea transplants, Benefits will be paid at the same level as *Professional Fees for Surgical and Medical Services*, *Outpatient Surgery, Diagnostic and Therapeutic Services*, and *Hospital - Inpatient Stay* rather than as described in this section *Transplantation Services*.). • Heart transplants, lung transplants or heart/lung transplants. (Benefit information continued on the next page)				

Description of Covered Health Service	Must You Obtain Prior Authorization?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• Kidney transplants, pancreas transplants or kidney/pancreas transplants. • Other transplants deemed appropriate by Care Coordination. • Liver transplants, small bowel transplants or liver/small bowel transplants. Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage. Under the Plan there are specific guidelines regarding Benefits for transplant services. Contact UnitedHealthcare at the telephone number on your ID card for information about these guidelines.				

(Benefit information continued on the next page)

Description of Covered Health Service	Must You Obtain Prior Authorization?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Transportation and Lodging UnitedHealthcare will assist the patient and family with travel and lodging arrangements only when services are received from a Designated Facility. Expenses for travel and lodging for the transplant recipient and a companion are available under this Plan as follows: • Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up. Eligible Expenses for lodging for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to $100 for two people. • Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Designated Facility. • If the patient is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed up to the $100 per diem rate. There is a combined overall lifetime maximum Benefit of $10,000 per Covered Person for all transportation and lodging expenses incurred by the transplant recipient and companion(s) and reimbursed under this Plan in connection with all transplant procedures.	***Network*** Yes Obtain prior authorization from UnitedHealthcare by contacting Care Coordination ***Out-of-Network*** **There Are No Benefits Available For Out-of-Network Designated Transplant Facilities**	15% if a Network designated transplant facility is used.	Yes	Yes

Description of Covered Health Service	Must You Obtain Prior Authorization?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
27. Urgent Care Center Services Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, benefits are available as described under *Physician's Office Services* earlier in the SPD.	***Network*** No	15%	Yes	Yes
	Out-of-Network No	40%	Yes	Yes
28. Wigs Wigs are excluded regardless of the reason for the hair loss, with the exception of hair loss relating to cancer/chemotherapy treatment. There is a lifetime maximum of $750 for wigs.	***Network*** No	0%	NA	Yes
	Out-of-Network No	0%	NA	Yes

Section 2: What's Not Covered Under this HRA Option-- Exclusions

This section contains information about:

- How headings are used in this section.
- Medical services that are not covered. We call these Exclusions regardless of medical necessity. This section lists some (but not all) of the things the plan does not cover at all, under any circumstances.

How We Use Headings in this Section

To help you find specific exclusions more easily, we use headings. The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion.

No Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in Section 1: What's Covered --Benefits. Amounts you pay for excluded services will never apply to deductibles or out-of-pocket maximums.

A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aroma therapy.
3. Hypnotism.
4. Massage Therapy.
5. Rolfing.
6. Environmental Medicine services or homeopathic/ holistic/alternative medicine services, including visits, diagnostic testing, labs, medications, or procedures from Providers of these practices.
7. Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

B. Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/Barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:

— Air conditioners.

— Air purifiers and filters.

— Batteries and battery chargers.

— Dehumidifiers.

— Humidifiers.

— Air cleaners and dust collection devices.

C. Dental

1. Dental care except as described in Section 1: What's Covered--Benefits under the heading *Dental Services - Accident Only*.
2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include all of the following:

— Extraction, restoration and replacement of teeth, including impacted wisdom teeth.

— Medical or surgical treatments of dental conditions.

— Services to improve dental clinical outcomes.

3. Dental implants or associated services such as bone grafts for the placement of dental implants.
4. Dental braces and Orthodontics.
5. Dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. The only exceptions to this are for any of the following:

— Transplant preparation.

— Initiation of immunosuppressives.

— The direct treatment of acute traumatic Injury, cancer or cleft palate, except as described in Section 1: What's Covered—Benefits under the heading *Dental Services - Oral Care.*

6. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a Congenital Anomaly, including but not limited Cleft Palate.
7. Alveoplasty; vestibuloplasty; apicoectomy; excision of mandibular tori or exostosis; occlusal devices or their adjustment; splints for bruxism (clenching or grinding of teeth), except as described in Section 1: What's Covered—Benefits under the heading Temporomandibular Joint Dysfunction (TMJ) and Oral Care.
8. Surgery, appliances or prostheses such as crowns, bridges or dentures; fillings; endodontic care, treatment of dental caries; excision of radicular cysts or granuloma; treatment of peridontal disease; and associated charges with any non-covered dental or oral service or supply; except as noted under Dental Surgery and Oral Care Surgery.

D. Drugs **Please refer to your Outpatient Prescription Drug Rider.

1. Prescription drug products for outpatient use that are filled by a prescription.
2. Self-injectable medications, a limited number of drugs identified by the Plan as appropriate for self-injection are covered under your Prescription Drug benefit. However, most injectable

medications are covered as medical benefits, subject to Coinsurance and the applicable Deductible. While for some Members self-injection may be medically appropriate, most Members will need to visit their Physicians' offices for injections and will receive coverage for their medications as medical benefits and not as Prescription Drug benefits. You can call your Pharmacy vendor to see if your medication is covered as a Prescription Drug benefit and to ask any related questions.

3. Non-injectable medications given in a Physician's office except as required in an Emergency.
4. Over-the-counter drugs and treatments except for certain preventive OTC drugs – Aspirin, Fluoride, Folic acid and Iron which require a prescription for coverage.
5. Infertility drugs/Reproduction medicines for treating a diagnosis of infertility, with the exception of diagnostic testing to rule out a diagnosis.
6. Growth hormone therapy.
7. Human chorionic gonadotropin (HCG) injections for infertility/reproductive medicine.
8. Prescription Drug Products for tobacco cessation (except for Over-the-Counter and Prescription Drug Products prescribed for participation in the Tobacco Cessation Telephonic Coaching Program).
9. Any drug administered for any purpose other than therapeutic treatment of an illness or injury.

E. Experimental, Investigational or Unproven Services

Experimental, Investigational and Unproven Services are excluded. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition. The Plan will cover procedures and supplies associated with cancer clinical trials that meet guidelines defined by the agreement between the Georgia Cancer Coalition and the Department of Community Health.

F. Foot Care

1. Routine foot care (including the cutting or removal of corns and calluses), with the exception of Covered Persons with diabetes or Covered Persons who are at risk of neurological or vascular diseases such as diabetes.
2 Nail trimming, cutting, or debriding, except for diabetic foot care.
3. Hygienic and preventive maintenance foot care. Examples include the following:

— Cleaning and soaking the feet.

— Applying skin creams in order to maintain skin tone.

— Other services that are performed when there is not a localized illness, Injury or symptom involving the foot.

4. Treatment of flat feet Fallen arches and chronic foot strain.
5. Treatment of subluxation of the foot.
6. Foot care devices such as arch supports and orthotics (except for the diagnosis of diabetes).
7. Shoes and footwear of any kind (except for therapeutic diabetic shoes) unless permanently attached to a covered brace.

G. Medical Supplies and Appliances

1. Devices used specifically as safety items or to affect performance in sports related activities.

2. Prescribed or non-prescribed medical supplies and disposable supplies (except when considered an integral part of covered Durable Medical Equipment). Examples include:

— Ace bandages.

— Gauze, dressings and tape.

— Surgical masks and gloves.

— Batteries and battery chargers.

— Syringes.

— Diabetic supplies, including but not limited to glucose monitors, test strips and lancets. ****Please refer to Outpatient Prescription Drug Rider**

— Lubricants and saline solutions.

3. Orthotic appliances that straighten or re-shape a body part (including cranial banding and some types of braces).
4. Tubings and masks are not covered except when used with Durable Medical Equipment as described in Section 1: What's Covered--Benefits.
5. Hot and cold packs.
6. Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement.
7. Blood pressure monitors and cuffs (unless related to dialysis).
8. Lift for scooters and wheelchairs, stair glides and elevators, and any other home modifications.
9. Devices and computers to assist in communication and speech.
10. Vacuum erection devices (VED, erect aid) to stimulate the penis.
11. Duplication, upgrade or replacement of currently functioning equipment.
12. Repair or replacement of Durable Medical Equipment due to damages caused by misuse, malicious breakage or gross neglect.
13. Replacement of lost or stolen Durable Medical Equipment.

H. Mental Health/Substance Use Disorder

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Services that extend beyond the period necessary for evaluation, diagnosis, the application of evidence-based treatments or crisis intervention to be effective.
3. Mental Health Services as treatment for a primary diagnosis of insomnia or other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis.
4. Treatment for conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by Mental Health/Substance Use Disorder Designee.
5. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction.
6. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements unless pre-authorized by the Mental Health/Substance Use Disorder Designee.
7. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance use disorders that , in the

reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following: (1) not consistent with generally accepted standards of medical practice for the treatment of such conditions; (2) not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental; (3) typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective; (4) not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time; or (5) not clinically appropriate in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks. The Mental Health/Substance Use Disorder Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

8. Recreational, educational or bio-feedback therapy, unless specifically approved by Mental Health/Substance Use Disorder Designee, or any form of self-care or self-help training or related diagnostic testing.
9. Marriage counseling, unless approved in advance by Mental Health/Substance Use Disorder Designee and conducted by a Mental Health/Substance Use Disorder Designee authorized provider.
10. Pastoral counseling.
11. Inpatient, intermediate or outpatient care services that were not pre-authorized by the Mental Health/Substance Use Disorder (MH/SUD) Administrator.
12. Substance Use Disorder Services for the treatment of nicotine or caffeine use.
13. Weight management programs not related to psychiatric condition.
14. Psychoanalysis for educational purposes, such as to complete degree or residency requirements.
15. Vocational or educational training/services and related psychological testing.
16. Hypnosis.
17. Routine use of psychological testing without specific authorization.
18. Experimental treatment performed for research.
19. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias (sexual behavior that is considered deviant or abnormal) and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as determined by the MH/SUD Administrator.
20. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
21. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act.*
22. Learning motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
23. Mental retardation as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

24. Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorders.
25. Mental Health Services as treatments for V-code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
26. Family therapy when patient is not present.
27. Residential treatment, Residential treatment facility, sub-Acute care; services of halfway house, supervised group home or boarding school. Boarding while attending a Partial Hospitalization Program.
28. The plan will not cover court ordered treatment that is not already a covered benefit and deemed medically necessary.
29. More than two CPT codes services on same day. A member is allowed one individual CPT code, one medical management and one group CPT per day.
30. Play Therapy.
31. Transcranial magnetic stimulation
32. Sensory Processing Disorders
33. Sensory Integration
34. Neurofeedback
35. Gender Reassignment
36. No Employee Assistance Program benefits.

I. Nutrition

1. Megavitamin and nutrition based therapy.
2. Nutritional counseling for either individuals or groups except as specifically described in Section 1: What's Covered--Benefits.
3. Nutritional and electrolyte supplements, including infant formula and donor breast milk. Enteral feedings are not covered except if it is the sole source of nutrition or for inborn errors of metabolism when approved by Care Coordination.
4. Minerals or metabolic deficiency formulas (except when approved by Care Coordination).

J. Physical Appearance

1. Cosmetic Procedures. See the definition in Section 11: Glossary of Defined Terms. Examples include:

— Pharmacological regimens, nutritional procedures or treatments.

— Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).

— Skin abrasion procedures performed as a treatment for acne.

2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure.
   Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in Section 1: What's Covered--Benefits.
3. Physical conditioning programs such as athletic training, body building, exercise, fitness, flexibility, and diversion or general motivation.
4. Weight loss programs and dietary supplements whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
5. Treatment for hair loss, including wigs regardless of the reason for the hair loss, medication or hair replacement, except diagnostic lab tests performed during initial diagnosis, See Section 1: What's Covered--Benefits.
6. Hair removal, including electrolysis.

7. Blepharoplasty (upper or lower eyelid), browplasty, brow lift (except when approved by Care Coordination).

K. Providers

1. Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal residence.
3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:

— Has not been actively involved in your medical care prior to ordering the service, or

— Is not actively involved in your medical care after the service is received.

   This exclusion does not apply to mammography testing.

4. Charges for professional services not rendered by the billing provider.

L. Reproduction

1. In vitro fertilization, gamete intrafallopian transfer (GIFT) procedures, and zygote intrafallopian transfer (ZIFT) procedures and any other reproductive technology.
2. Surrogate parenting.
3. The reversal of voluntary sterilization.
4. Infertility monitoring, correction or treatment, including drugs, in-vitro fertilization and other reproductive technologies.
5. Storage of egg, sperm or blood product for future use.
6. Infertility drugs and reproductive medicines for treating a diagnosis of infertility.

M. Services Provided under Another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

   If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.
2. Health services for treatment of military service related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health services while on active military duty.

N. Transplants

1. Health services for organ and tissue transplants, except those described in Section 1: What's Covered--Benefits.
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan).

3. Health services and expenses for transplants involving artificial, mechanical or animal organs.
4. Transplant services that are not performed at a Designated Facility.
5. Any solid organ transplant that is performed as a treatment for cancer.
6. Lodging related, except as defined in Section 1: What's Covered-Benefits Transplantation Services to the donation or transplantation of an organ.
6. Expenses for an artificial, mechanical or animal organ transplant.
7. Transplant therapy used as a palliatative procedure. Transplant therapy considered experimental, please refer to Section E.
8. Any multiple organ transplants not listed as a Covered Health Service under the heading *Transplantation Health Services* in Section 1: What's Covered--Benefits.

O. Travel

1. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to covered transplantation services may be reimbursed as outlined in the Transplantation Service section.

P. Vision and Hearing

1. Purchase cost of eye glasses or contact lenses, except as described in Section 1: What's Covered--Benefits under the heading *Eye Examinations*.
2. Fitting charge for eye glasses or contact lenses, except as described in Section 1: What's Covered--Benefits under the heading *Eye Examinations*.
3. Eye exercise therapy, orthoptic training.
4. Telephonic/online hearing test and evaluations are not covered.
5. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, LASIK and other refractive eye surgery.
6. Diagnosis, treatment or surgical and non-surgical correction of far-sightedness, near-sightedness or astigmatism. Any vision care, including lo-vision and other vision aids.
7. Tinnitis therapy, including sound generators.

Q. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service see the definition in Section 11: Glossary of Defined Terms. Covered Health Services are those health services including services, supplies or Prescription Drugs, which the Claims Administrator determines to be all of the following:

— Medically Necessary;

— described as a Covered Health Service in this Summary Plan Description; and

— not otherwise excluded in this Summary Plan Description under this Section 2, What's Not Covered.

This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement.

2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when:

— Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption.

— Related to judicial or administrative proceedings or orders.

— Conducted for purposes of medical research.

— Required to obtain or maintain a license of any type.

3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
4. Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.
6. In the event that an Out-of-network-Network provider waives Coinsurance and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which the Coinsurance and/or Annual Deductible are waived.
7. Charges in excess of Eligible Expenses or in excess of any specified limitation.
8. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), unless otherwise specified in the TMJ section.
9. Medical and surgical treatment of adult obesity/morbid obesity including, but not limited to, bariatric surgical procedures, gastric restrictive procedures, gastric bypass procedures, weight reduction surgery and revisions, and lap band adjustments, (unless previously approved by Care Coordination from 1/1/2010 through 12/31/2011). Non-surgical treatment of obesity/morbid obesity, for example Optifast, Weight Watchers, Jenny Craig, etc. Panniculectomy, abdominoplasty, repair of diastasis recti, tummy tuck, excision of excessive skin and/or subcutaneous tissue, and liposuction. Refer to Section #1 (Physician Office Services and Nutritional Counseling) for Childhood Obesity limitations.
10. Sex transformation operations.
11. Custodial Care.
12. Domiciliary care.
13. Private duty nursing.
14. Respite care.
15. Rest cures.
16. Psychosurgery.
17. Treatment of benign gynecomastia (abnormal breast enlargement in males).
18. Medical and surgical treatment of excessive sweating (hyperhidrosis).
19. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
20. Oral appliances for snoring.
21. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, a Congenital Anomaly, or as mandated by state law for treatment of autism.
22. Any charges for missed appointments, room or facility reservations, completion of claim forms, record processing, cost of obtaining or copying of medical records.
23. Any charge for services, supplies or equipment advertised by the provider as free.
24. Any charges prohibited by federal anti-kickback or self-referral statutes.
25. Therapy for non-covered diagnoses.
26. Re-habituation therapy.
27. Inpatient therapies such as rehabilitation, rehabilitative therapy or restorative therapy, unless significant improvement is expected within a reasonable and generally predictable period of time following an acute illness.

28. Transitional living programs, day treatment programs related to senior/adult care treatment, assisted living, non-skilled assisted care, nursing homes, personal care homes, extended care facilities, cognitive remediation therapy.
29. Specific needs enhancement therapy for education, employment or motivation.
30. Educational evaluations or neurolinguistcal programming.
31. Lab charges and other charges not related to spinal care, when provided by a Spinal Treatment provider.
32. DME, except for certain neck and back braces when provided by a Spinal Treatment provider.
33. Vax-D therapy.

Section 3: Description of Network and Out-of-Network Benefits Under this HRA Option

This section includes information about:

- Network Benefits.
- Out-of-Network Benefits.
- Emergency Health Services.

Network Benefits

Network Benefits are generally paid at a higher level than Out-of-Network Benefits. Network Benefits are payable for Covered Health Services which are either of the following:

- Provided by a Network Physician, Network facility or other Network provider.
- Emergency Health Services.

Please note that Mental Health and Substance Use Disorder Services must be authorized by Mental Health/Substance Use Disorder Designee. Please see Section 1: What's Covered--Benefits under the heading for *Mental Health and Substance Use Disorder*.

Comparison of Network and Out-of-Network Benefits

	Network	Out-of-Network
Benefits	A higher level of Benefits means less cost to you. See Section 1: What's Covered--Benefits.	A lower level of Benefits means more cost to you. See Section 1: What's Covered--Benefits.
Who Should Obtain Prior Authorization from Care Coordination	Network providers generally handle notification for you. However, there are exceptions. See Section 1: What's Covered—Benefits, under the *Must You Obtain Prior Authorization? Column*.	You must Obtain Prior Authorization from UnitedHealthcare for certain Covered Health Services. Failure to obtain prior authorization results in a non-prior authorization penalty of 50% of Eligible Expenses, or no Benefits. See Section 1: What's Covered--Benefits, under the *Must You Obtain Prior Authorization? Column*.
Who Should File Claims	Network providers will file the claim.	You must file claims. See Section 6: How to File a Claim.

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Outpatient Emergency Health Services	Emergency Health Services are always paid as a Network Benefit (paid the same whether you are in or out of the Network). That means that if you seek Emergency care at a non-Network facility, you are not required to pay any difference between Eligible Expenses and the amount the provider bills.

Provider Network

UnitedHealthcare arranges for health care providers to participate in a Network. Network Providers are independent practitioners. They are not our employees or employees of UnitedHealthcare. It is your responsibility to select your provider.

The credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

You will be given a directory of Network Providers. However, before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling UnitedHealthcare.

It is possible that you might not be able to obtain services from a particular Network Provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network Provider to get Network Benefits.

Do not assume that a Network Provider's agreement includes all Covered Health Services. Some Network Providers contract to provide only certain Covered Health Services, but not all Covered Health Services. Some Network Providers choose to be a Network Provider for only some products. Contact UnitedHealthcare for assistance to be sure that a provider is a Network Provider for purposes of the treatment you will be receiving.

Care Coordination[SM]

Your Network Physician is required to obtain prior authorization from UnitedHealthcare regarding certain proposed or scheduled health services. When your Network Physician notifies UnitedHealthcare, they will work together to implement the Care Coordination[SM] process and to provide you with information about additional services that are available to you, such as disease management programs, health education, pre-admission counseling and patient advocacy.

If you receive certain Covered Health Services from a Network provider, you must obtain prior authorization from UnitedHealthcare. The Covered Health Services for which notification is required is shown in Section 1: What's Covered--Benefits. When you obtain prior authorization from UnitedHealthcare, you will receive the Care Coordination services described above.

Designated Facilities and Other Providers

If you have a medical condition that UnitedHealthcare believes needs special services, they may direct you to a Designated Facility or other provider chosen by them. If you require certain complex Covered Health Services for which expertise is limited, UnitedHealthcare may direct you to a non-Network facility or provider.

In both cases, Network Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility or other provider chosen by UnitedHealthcare.

You or your Network Physician must obtain prior authorization from UnitedHealthcare of special service needs (including, but not limited

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to, transplants or cancer treatment) that might warrant referral to a Designated Facility or Out-of-Network Facility or provider. If you do not obtain prior authorization from UnitedHealthcare in advance and if you receive services from an Out-of-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Network Benefits will not be paid. Out-of-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Plan.

Limitations on Selection of Providers

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, you may be required to select a single Network Physician to provide and coordinate all future Covered Health Services. You may appeal this decision to UnitedHealthcare

If you don't make a selection within 31 days of the date we notify you, UnitedHealthcare will select a single Network Physician for you.

If you fail to use the selected Network Physician, Covered Health Services will be paid as Out-of-Network Benefits.

Hospital Based Physicians

Non-participating Physicians sometimes practice in Network Hospitals. As a result, you may receive care in a Network Hospital from a Non-Network Hospital-based Physician, including providers such as pathologists, radiologists, or anesthesiologists.

Covered Services from Non-Network Hospital-based Physicians received in a Network Hospital will be covered at the Network benefit level. However, you may be subject to balance billing.

Out-of-Network Benefits

Out-of-Network Benefits are generally paid at a lower level than Network Benefits. Out-of-Network Benefits are payable for Covered Health Services that are provided by Non-Network providers.

Depending on the geographic area and the service you receive, you may have access through UnitedHealthcare's Shared Savings Program to providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, and if your Coinsurance is expressed as a percentage of Eligible Expenses for Non-Network Benefits, that percentage will remain the same as it is when you receive Covered Health Services from Non-Network Providers who have not agreed to discount their charges; however, the total that you owe may be less when you receive Covered Health Services from Shared Savings Program providers than from other Non-Network Providers, because the Eligible Expense may be a lesser amount. Refer to "Eligible Expenses" Glossary term for details.

Notification Requirement

You must obtain prior authorization from UnitedHealthcare before getting certain Covered Health Services from non-Network providers. The details are shown in the *Must You Obtain Prior Authorization?* column in Section 1: What's Covered--Benefits. If you fail to obtain prior authorization from, Benefits are reduced or denied.

Prior notification does not mean Benefits are payable in all cases. Coverage depends on the Covered Health Services that are actually given, your eligibility status, and any benefit limitations.

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Care Coordination℠

When you obtain prior authorization from UnitedHealthcare as described above, they will work with you to implement the Care Coordination℠ process and to provide you with information about additional services that are available to you, such as disease management programs, health education, pre-admission counseling and patient advocacy.

Emergency Health Services

We provide Benefits for Emergency Health Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician.

Network Benefits are paid for Emergency Health Services, even if the services are provided by a non-Network Provider.

If you are confined in a non-Network Hospital after you receive Emergency Health Services, UnitedHealthcare must be notified within one business day or on the same day of admission if reasonably possible. UnitedHealthcare may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date UnitedHealthcare decides a transfer is medically appropriate, Out-of-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.

True Emergency eligible medical services rendered outside the United States are subject to plan guidelines. All foreign claims and medical records should be submitted for medical review to: United Health Group, International Claims, and P. O. Box 740817, Atlanta, GA 30374. Emergency health services determined to be a covered health service will be paid at the network benefit and non-emergency health services at the non-network benefit.

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International Claim form can be obtained at www.welcometouhc.com/shbp.

Section 4: Eligibility for SHBP as an Active Employee; When Coverage as an Active Employee Begins and Ends

This section includes information about:

- How to enroll.
- If you are hospitalized when this coverage begins.
- Who is eligible for coverage.
- When to enroll.
- When coverage begins.

How to Enroll

To enroll, the Eligible Person should contact his or her Payroll location for instructions on enrolling within 31 days of hire. SHBP will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

If you are inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, SHBP will pay Benefits from the day coverage begins for Covered Health Services related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Plan.

You should notify Care Coordination within 48 hours of the day your coverage begins, or as soon as reasonably possible. In-Network Benefits are available only if you receive Covered Health Services from Network Providers.

Who is Eligible for Coverage

Who	Description	Who Determines Eligibility
Eligible Person	Complete eligibility rules are set forth in SHBP statutes and regulations, and the rules in the statutes and regulations control if there is a conflict with this summary. Although currently operated as one plan, there are actually three plans that make up the SHBP: a plan for State employees described in O.C.G.A. Section 45-18-1, a plan for public school teachers described in O.C.G.A. Section 20-2-881, and a plan for public school service personnel other than teachers described in O.C.G.A. Section 20-2-911. **Eligibility rules for the plan for State employees.** "Regular full-time" means you are scheduled to work at least 30 hours a week and you work at least 30 hours a week consistently. "Full-time" employee means you are classified by your employer as a full-time employee. "Part-time" employee means you are classified by your employer as a part-time employee. Not Eligible: individuals classified by the employer as temporary (expected to work less than nine months), seasonal, intermittent workers or independent contractors. In general, you are eligible to enroll yourself and your eligible dependents for coverage if you meet one of the descriptions below. • A regular full-time employee of a department, board, agency or commission, General Assembly, or community service board of the State of Georgia,	The Plan Administrator determines who is eligible to enroll under the Plan.

Who	Description	Who Determines Eligibility
	• A part-time employee of the General Assembly who had coverage prior to January 1981 or an administrative or clerical employee of the General Assembly, • A full-time district attorney, assistant district attorney or a district attorney's investigator of the superior courts appointed pursuant to O.C.G.A. Section 15-18-14, • A full-time secretary or law clerk employed by district attorneys and judges and employed under O.C.G.A. Sections 15-18-17-19, • A regular full-time employee who receives salary or wage payment from a county board of health or county board of family and children services, • A member of the General Assembly, • A regular full-time employee of a State authority that participates in the Employees' Retirement System and participates in the Plan by paying all required contributions to the Plan, • A regular full-time employee of an entity that offers the Plan to its employees pursuant to a current contract with the Department of Community Health. • In some cases, employees described above may continue SHBP coverage after resignation with 8 or more Years of Service or retirement with an annuity. See Section 5 for details. Employees who terminate employment with less than 8 Years of Service may be able to continue SHBP coverage through COBRA. See Section 9.	The Plan Administrator determines who is eligible to enroll under the Plan.

Who	Description	Who Determines Eligibility
	Eligibility rules for the plan for public school teachers. Teachers who are employed not less than half time, which must be at least seventeen and a half (17½) hours per week, in the public school systems of Georgia are eligible to participate. An eligible teacher shall not include any independent contractor, emergency or temporary worker, or person employed by a charter school that has not elected to offer SHBP coverage, or that has revoked SHBP coverage. Eligible teachers must be employed not less than half time, which must be at least seventeen and a half (17½) hours per week, and are further defined as: • A person employed in a professionally certificated capacity or position in the public school systems of Georgia; • A person compensated in a professionally certificated capacity or position in a charter school that has elected to offer SHBP coverage and has not revoked SHBP coverage; • A person employed by a regional or county library of Georgia; • A person employed in a professionally certificated capacity or position in the public vocational and technical schools operated by a local school system; • A person employed in a professionally certificated capacity or position in the Regional Educational Service Areas of Georgia; • A person employed in a professionally certificated capacity or position in the high school program of the Georgia Military College. • In some cases, employees described above may continue SHBP coverage after resignation with 8 or more Years of Service or retirement with an annuity. See Section 5 for details. Employees	The Plan Administrator determines who is eligible to enroll under the Plan.

who terminate employment with less than 8 Years of Service may be able to continue SHBP coverage through COBRA. See Section 9.

Eligibility rules for the plan for other public school employees.

The Plan Administrator determines who is eligible to enroll under the Plan.

- Any person who is not eligible under the rules above for the plan for public school teachers, who is employed by a local school system that has not withdrawn from the plan for public school employees in accordance with requirements of the DCH, or who is employed by a charter school that has elected to offer SHBP coverage and has not revoked SHBP coverage, and who meets the following work requirements:

— If you are eligible to participate in the Teachers Retirement System or its local equivalent, you must work at least 60% of a standard schedule for the position, as determined by the employer, but not less than 20 hours a week, and you may not be classified by your employer as an independent contractor or emergency or temporary worker.

— If you are eligible for the Public School Employees' Retirement System, you must work at least 60% of the standard schedule for your position, but not less than 15 hours a week, and not be employed as an independent contractor or on an emergency or temporary basis.

— If you are an employee of a charter school who is not working in a certificated position or capacity, you must work at least half-time, and not be employed as an independent contractor or on an emergency or temporary basis.

Who	Description	Who Determines Eligibility
	• In some cases, employees described above may continue SHBP coverage after resignation with 8 or more Years of Service or retirement with an annuity. See Section 5 for details. Employees who terminate employment with less than 8 Years of Service may be able to continue SHBP coverage through COBRA. See Section 9.	
Dependent **Eligible Dependents are:**	**Your legally married spouse; as defined by Georgia law.** (1) **Natural or legally adopted children or Stepchildren, under age 26.** Natural Child – child for which the natural guardian has not relinquished all guardianship rights through a judicial decree. Eligibility begins at birth. Adopted Child – eligibility begins on the date of legal placement for adoption. Stepchild – eligibility begins on the date of marriage to the natural parent. Eligibility ends at the end of the month in which the child reaches age 26 or at the end of the month in which he or she loses status as a step child of the enrolled member, whichever date is earlier. (2) **Other children under 26**. A dependent child for whom the enrolled member is the legal guardian. Eligibility begins on the date legal guardianship is established and ends at the end of the month in which the child reaches age 26 or at the end of the month in which the legal guardianship terminates, whichever is earlier. (3) **Your natural children, legally adopted children or stepchildren 26 or older from categories 1 and 2** above who are (i) physically or mentally disabled prior to age 26, and are primarily dependent on the Enrolled member for support and maintenance. (Information continued on next page)	The Plan Administrator determines who is eligible to enroll under the Plan.

Who	Description	Who Determines Eligibility
For a Covered Dependent age 26 & older and disabled before age 26	**You must:** • file a written request for continuation of coverage within 31 days of the 26th birthday • when requested by the Plan you must re-certify your dependent(s). If you fail to re-certify your dependent within 31 days of the request, your dependent will no longer be eligible to be covered under the Plan until verification is received. **If documentation is received after 31 days, the plan will cover the dependent retroactively to the beginning of the current plan year or date of qualifying event, whichever is later, as long as the correct tier premium is paid.**	The Plan Administrator determines who is eligible to enroll under the Plan.
To enroll a disabled child as a new dependent (child must be disabled prior to age 26)	**You must:** • make request within 31 days of your hire date or qualifying event date OR add during Open Enrollment period; and • provide medical documentation that must be approved by the Plan **A general note regarding documentation sent to the Plan: While the Plan requires that coverage requests are made within a specific time period, the documentation required *to support your request* may be filed later, if necessary, within the 31 days following the deadline to file the coverage request.**	The Plan Administrator determines who is eligible to enroll under the Plan.

Who	Description	Who Determines Eligibility
Qualified Medical Child Support Order (QMCSO)	SHBP will honor a QMCSO for eligible dependents. A QMCSO creates, recognizes, or assigns the right for a dependent to receive benefits under a health plan. See Glossary of Key Terms and Coverage Changes At Qualifying Events for more information.	The Plan Administrator determines who is eligible to enroll under the Plan.
Who's Not Eligible For Dependent Coverage	The most common examples of persons not eligible for SHBP dependent coverage include: • Your former spouse • Your fiancé • Your parents • Children age 26 or older who do not qualify as disabled dependents • Grandchildren who cannot be considered eligible dependents Anyone living in your home that is not related by marriage or birth, unless otherwise noted.	The Plan Administrator determines who is eligible to enroll under the Plan. NOTE: If you misrepresent eligibility information when applying for coverage, during a change in coverage or when filing for benefits, or by paying for coverage on behalf of someone who is not eligible, adverse action may be taken against you by DCH or applicable enforcement agencies. Adverse actions include, but are not limited to: terminating your coverage, collection actions for all payments improperly made as a result of the misrepresentation, and criminal prosecution.

When to Enroll and When Coverage Begins

You must enroll to have SHBP coverage

To enroll, go to your personnel/payroll office for instructions. You will be asked to:

- Choose a coverage option
- Choose a coverage tier

Provide the name(s) of eligible dependents you want to enroll and cover. If newly enrolling in the plan because you are a new employee, because of Open Enrollment or a qualifying event, your plan options are restricted to the standard consumer driven health plan options:

The Health reimbursement Arrangement (HRA) and High Deductible Health Plan (HDHP) Enrollment authorizes periodic payroll deductions for premiums. If you list dependent(s) you must elect a coverage tier that covers the dependent(s) by relationship to you. If you cover dependents and do not provide documentation to verify eligibility, you will be charged the tier you elected. Once dependents are verified, the coverage will be effective from the date of the qualifying event or the 1st day of the current plan year, whichever is later. Please refer to "Who is eligible for coverage" for more information. Once you make your coverage election, changes are not allowed outside the Open Enrollment period, unless you have a qualified change in status under Section 125 of the Internal Revenue Code, which restricts changes to coverage in the SHBP – outside the annual Open Enrollment Period.

Important Plan Membership Terms

This SPD uses these terms to describe Plan Membership:

- Enrolled Member – You, the contract/policy holder
- Dependent(s) – your eligible dependent(s) that you choose to enroll

Contributions Surcharge Policy

Tobacco Surcharge:

A tobacco surcharge of $80 is added to your monthly premium if you failed to answer the tobacco surcharge questions during your Initial Enrollment, Open Enrollment or the Retiree Option Change Period or if you answered that a covered member of your family used tobacco products in the previous sixty days. The tobacco surcharge may be removed by following the tobacco surcharge removal procedures found on the Department of Community Health website, www.dch.georgia.gov/shbp. For further details refer to Plan Highlights in Section #1 (What's Covered – Benefits). You are required to pay the tobacco surcharge for all months in which you or any of your enrolled family members use tobacco. Therefore, it is your responsibility to notify DCH, SHBP Division immediately if your answers to the tobacco surcharge questions change during the year. If you received a waiver of the tobacco surcharge based on your answers and you fail to notify DCH, SHBP Division that you or a member of your enrolled family members begins using tobacco, this may be viewed as an intentional misrepresentation.

Note: The Tobacco Surcharge does not apply to options that include Medicare Advantage (MA) coverage or to retirees who are eligible

and did not enroll in a MA option and chose another option where they pay 100 percent of the premiums for their health coverage.

Intentional misrepresentation in response to the tobacco surcharge questions or failure to notify DCH, SHBP Division of changes to your responses to the surcharge will have significant consequences. Active employees will lose State Health Benefit Plan coverage for 12 months beginning on the date that your false response or failure to notify is discovered. Retirees who intentionally misrepresent the response to the tobacco surcharge questions or fail to notify DCH, SHBP Division of changes to their responses will permanently lose their SHBP health insurance.

Enrollment Periods

When to Enroll	Who Can Enroll	Enrollment Information
Initial Enrollment Period The Initial Enrollment Period is the first period of time when Eligible Persons can enroll.	Eligible Employees may enroll themselves and their Dependents.	Enrollment must be completed within 31 days of your date of hire.
Open Enrollment Period	Open Enrollment occurs every fall for the following plan year. Eligible Persons may enroll themselves and their Dependents. Any Dependent(s) removed during the Open Enrollment period are not eligible for COBRA. However, if a dependent spouse is removed during the Open Enrollment period because of anticipated divorce, the former dependent spouse may elect COBRA once the divorce is finalized.	The Plan Administrator determines the Open Enrollment Period. Coverage begins on January 1st, of the following Plan year

When to Enroll	Who Can Enroll	Enrollment Information
A current employee*	• Enroll • Make coverage changes during Open Enrollment • Make coverage changes within 31 days of a qualified event (90 days for newly eligible dependent child) (Refer to the *Dependent* heading in this Section)	• The upcoming January 1 • First of the month following request
A newly hired employee*	• Enroll in a Standard consumer driven health plan option (the Standard Health Reimbursement Arrangement or Standard High Deductible Health Plan) within 31 days of your hire date	• First of the month after a full calendar month of employment

A rehire with the same employer or another employer that offers SHBP coverage	• If the rehire occurs within the same plan year, you must retain the same SHBP option you had, even if there is a gap in coverage.
	• If the termination of employment is in one year and you are re-hired in the following year, with a gap in coverage, you are restricted to the Standard consumer driven health plan options:
	  • the Standard Health Reimbursement Arrangement (HRA), and
	  • Standard High Deductible Health Plan (HDHP) with the new employer.
	Once enrolled, you may elect other health plan options during the following Open Enrollment.
		• First of the month following a salary deduction for Plan coverage

Enrolling A Newly Eligible Dependent

If you have a new dependent due to marriage, birth, adoption, guardianship, you may enroll your dependent(s) if you request coverage within 31 days of the qualifying event (90 days to add a newly eligible dependent child). Please contact your personnel/payroll office for instructions**. The DCH, SHBP Division must collect the Social Security Number (SSN) for each dependent age two or older. Do not wait for verification documentation to enroll dependent(s). The SSN is not required for a dependent child until age two. However, failure to provide the SSN when the child reaches age two will result in termination of coverage for the dependent child. Provide the SSN for a dependent child as soon as it is available.**

The next section describes what you need to do if you wish to add a newly eligible dependent.

	To Enroll A Newly Eligible Dependent And…	You Will Need To:
Newly Eligible Dependent	• If your dependent is currently eligible for the tier you are enrolled in • If your current tier does not cover dependents	• You must add within 31 days of the marriage, or adoption (90 days for newly eligible dependent child) • You must change tier within 31 days of qualifying event, pay appropriate premium, and add dependent • You must add within 90 days of the birth regardless if natural, legal or step child

To Enroll A Newly Eligible Dependent And…	You Will Need To:
• If you have a court order that requires you to enroll dependent child(ren)	• Submit the order to SBHP for approval. If DCH, SHBP Division approves the court order as a QMCSO, you will be able to enroll the dependent child(ren). • Enroll the eligible child(ren); coverage starts on first day of month following the request. • You must change tier and pay appropriate premium if current tier does not include dependent(s)

Identification Cards

After you enroll, you will receive an identification (ID) card for yourself and eligible dependent(s), if applicable. The ID card must be presented when care is received.

If you do not receive your ID card within two weeks of new enrollment, or by January 1st for changes made during Open Enrollment or the Retiree Option Change Period, please contact United HealthCare Services, Inc. Customer Service at 877-246-4189 (Active) or 877-246-4190 (Retiree).

When Coverage Begins

When your coverage starts depends on when you enroll and when you make requests that affect your coverage.

	If You Enroll:	Your Coverage Begins:
For Transferring Employees	If you are transferring between employers that offer SHBP coverage: • Contact your new employer to coordinate continuous coverage • You must continue the same coverage and tier, unless you had a qualifying event that allows a change in coverage	• There is no coverage lapse when your employment break is less than one calendar month and your new employer deducts the premium from your first paycheck. • If there is a break in employment with employers that offer SHBP coverage that is longer than one calendar month, the coverage begins on the first day of the month following one full month of employment.
For You	• During an Open Enrollment period	• On January 1st of the new Plan year
	• As a new employee	• On the first day of the month following one full calendar month of employment
	• When you are reinstated or return to work from an unpaid leave of absence that occurred during an Open Enrollment period	• On the first day of the month following the return or, if a judicial reinstatement, on the day specified in the settlement agreement
	• When you have a qualifying event	• On the first day of the month following the request and receipt and processing of the appropriate dependent documentation

For Your Dependents

See Chart on next page for required Documentation

As a new employee, dependent coverage begins when your coverage begins. If you add dependents within 31 days (90 days for newly eligible dependent child)of a qualifying event, coverage takes effect as described in this Section under the heading *Adding Dependents* and the chart on the next page. The Centers for Medicare & Medicaid Services (CMS) regulations now require the DCH, SHBP Division to collect the Social Security Number (SSN) for each covered dependent. You must submit the following documentation to: SHBP, P. O. Box 1990, Atlanta, Georgia 30301-1990 before claims will be paid. You should provide DCH, SHBP Division the SSN for your dependent child as soon as it is available, but no later than age two.

Note: Do not hold request waiting for documentation. If documentation is received after 31 days, the plan will cover the dependent retroactively back to the beginning of the current plan year or date of qualifying event, whichever is later, as long as premiums are paid.

Adding Dependents

When you add a dependent the Plan will request dependent verification documentation. You must submit the documentation requested by the Plan in order to cover the dependent. **CMS regulations now require the DCH, SHBP Division to capture the Social Security Number (SSN) for each covered dependent. If documentation and the SSN is received after 31 days (except for newborn, the plan will cover the dependent retroactively back to the beginning of the current plan year or date of qualifying event, whichever is later, as long as the correct tier premium is paid. The SSN is not required for a dependent child until age two. However, failure to provide the SSN when the child reaches age two will result in termination of coverage for the dependent child. Provide the SSN for a dependent child as soon as it is available.**

Note: The dependent's coverage will remain inactive until the appropriate documentation has been received and verified by DCH, SHBP Division.

If You Add This Dependent:	Provide This Documentation:	Coverage Takes Effect:
A baby Within 90 days prior to or after the qualifying event	• Copy of certified birth certificate or a birth card issued by the hospital listing parents by name **Note**: A birth document that does not include the parents' names is not acceptable.	• On the first day of the month following the request; or • On the day your child was born, if the proper premiums are paid, starting with premiums for the birth month
An adopted child Within 31 days prior to or after the qualifying event (90 days if adopted child is a newly eligible dependent child)	• A certified copy of court documents establishing adoption and stating the date of adoption or if adoption is not finalized, certified or notarized legal documents establishing the date of placement for adoption	**When you already have coverage that includes children:** • On the date of legal placement and physical custody **When you do not have a tier that covers dependent children** • On the date of legal placement and physical custody, if the proper premiums are paid, starting with the month of placement and physical custody

If You Add This Dependent:	Provide This Documentation:	Coverage Takes Effect:
Disabled Child **Within 31 days of the child becoming disabled and the disabled dependent child:** • Is un-able to be self-supporting because of mental or physical disability. • Depends mainly on the Member for support. • Was disabled prior to age 26. • Meets SHBP disability requirements.	• Copy of certified birth certificate or a certification letter of birth card issued by the hospital listing parents by name. • Social Security Number • Proof of the child's disability and dependency requirements furnished to DCH, SHBP Division within 31 days of: enrollment in the Plan; or date coverage would otherwise have ended because the disabled dependent child reached age 26 DCH, SHBP Division may periodically ask you for proof that the Member's child continues to meet these conditions of disability and dependency.	• On the first of the month following approval of the medical documentation submitted to DCH, SHBP Division • When you have changed tiers to cover the disabled dependent child

If You Add This Dependent:	Provide This Documentation:	Coverage Takes Effect:
A new spouse Within 31 days prior to or after the qualifying event	• Copy of certified marriage certificate and Social Security Number	• On the first day of the month following the request
Stepchild(ren) Within 31 days prior to or after the qualifying event (90 days if a newly eligible dependent child)	• Copy of certified birth certificate showing your spouse is the natural parent; and copy of certified marriage license showing the natural parent is your spouse; or copy of your most recent Federal Tax Return (filed jointly with spouse) including legible signatures for you and your spouse with financial information blacked out and Social Security Number. **Note**: A birth document that does not include the parent's name is not acceptable.	• On the first day of the month following the qualifying event or your change to the appropriate coverage tier
A natural child due to a Qualified Medical Child Support Order (QMCSO)	• Social Security Number • Copy of the court order listing children that you must cover	• On the first day of the month following the request, if DCH, SHBP Division approves the court order as a QMCSO.

Qualifying Events that Allow Coverage Changes for Active Employee Members

If you are an actively employed Member and have one of the following qualifying events during the year, you may be able to make a coverage change that is consistent with the qualifying event. If you are a retiree, refer to the retiree section for permitted coverage changes. **CMS regulations now require the DCH, SHBP Division to capture the Social Security Number (SSN) for each covered dependent. The SSN is not required for a dependent child until age two. However, failure to provide the SSN within when the child reaches age two will result in termination of coverage for the dependent child. Provide the SSN for a dependent child as soon as it is available.**

Please contact your personnel/payroll office for instructions. Changes must be reported within 31 days of the event (90 days for newborn) to your personnel/payroll office or to the DCH, SHBP Division by calling 1-800-610-1863.

Note: Loss of all covered dependents may be through divorce, death, an only covered dependent exceeding the maximum age of eligibility, or a Qualified Medical Child Support Order QMCSO requiring a former spouse to provide health coverage for all covered natural children. You must notify DCH, SHBP Division within 31 days of qualifying event to change your coverage tier (90 days for newly eligible dependent child). Your next opportunity to change coverage tier would be during the next Open Enrollment.

The following chart shows qualifying events and the corresponding changes that active Members can make. If you are newly enrolling in the health plan because of a qualifying event, your plan options are restricted to the Standard consumer driven health plan options: the Standard Health Reimbursement Arrangement (HRA) and the Standard High Deductible Health Plan (HDHP) for the first plan year. Once enrolled, you may elect other health plan options during the following Open Enrollment.

If You Have One Of These Qualifying Events:	Provide This Documentation:	Within 90 Days Of Qualifying Event, You May / Must:
Birth **Note**: The Social Security Number is not required until age two. Failure to provide the Social Security Number at age two will result in termination of coverage for the dependent child.	• Copy of certified birth certificate or birth card issued by the hospital listing parents by name.	• Enroll in coverage • Change coverage tier to include child(ren) • Enroll eligible dependents • Change to any available option for you + child(ren) or you +family

If You Have One Of These Qualifying Events:	Provide This Documentation:	Within 31 Days Of Qualifying Event, You May / Must:
Marriage	• Certified copy of marriage certificate required • Spouse's Social Security Number	• Enroll in coverage • Change coverage tier to include spouse • Change coverage option to elect new coverage for you + spouse or you +family • Discontinue coverage; letter from other plan documenting you and your covered dependents are enrolled in spouse's plan. The letter should include the names of all covered dependents.
Adoption (90 days if adopted child is a newly eligible dependent child), legal guardianship **Note:** The Social Security Number is not required until age two. Failure to provide the Social Security Number when the child reaches age two will result in termination of coverage for the dependent child.	• **Adoption**: Adoption certificate or court order placing child in home • **Legal guardianship**: Certified copy of court documents establishing adoption and stating the date of adoption, or, if adoption is not finalized, certified or notarized legal documents establishing the date of placement for adoption. If certified copy of the birth certificate is not available, other proof of the child's date of birth is required.	• Enroll in coverage • Change coverage tier to include child(ren) • Enroll eligible dependents • Change to any available option for you + child(ren) or you +family **Note**: You have 90 days for a newly eligible dependent child

If You Have One Of These Qualifying Events:	Provide This Documentation:	Within 31 Days Of Qualifying Event, You May / Must:
Divorce	**Adding coverage for yourself** • Copy of divorce decree and loss of coverage documentation required • Furnish Social Security Number for each dependent you wish to cover **Removing a former spouse from coverage** • Copy of divorce decree	• Enroll in coverage, if losing coverage through spouse's plan • Must remove spouse from coverage • Must remove step children from coverage • Change coverage tier • Enroll eligible dependents • Change coverage option to elect new coverage for you or you + child(ren)

If You Have One Of These Qualifying Events:	Provide This Documentation:	Within 31 Days Of Qualifying Event, You May / Must:
If a court order approved by DCH, SHBP Division as a QMCSO requires:		You can:
You to provide coverage for your natural child(ren)		Enroll or change coverage tier – there is no time limit for this change; documentation of the court order is required
Your former spouse must provide coverage for each of your enrolled natural child(ren)		Change coverage tier; documentation of the court order and the other coverage is required
Spouse to provide coverage for his/her natural children Furnish Social Security Number and dependent verification documentation for each dependent you wish to cover		Enroll or change coverage tier – no time limit for this change; documentation of the court order requiring coverage is required

If You Have One Of These Qualifying Events:	Provide This Documentation:	Within 31 Days Of Qualifying Event, You May / Must:
You or your spouse lose coverage through other employment	• Letter from other employer documenting loss of coverage and reason for loss is required • Furnish Social Security Number and dependent verification for each dependent you wish to cover	• Enroll eligible dependent(s) • Enroll In Coverage • Change coverage tier • Change coverage option to elect new coverage for you, you + spouse, or you + child(ren), or you + family
You, your spouse, or enrolled dependent are covered under a qualified health plan and you lose eligibility, such as through other employment, Medicaid*, State Children's Health Insurance Program (SCHIP) or Medicare	• Furnish Social Security Number and dependent verification for each dependent you wish to cover • Letter from other employer, Medicaid, or Medicare documenting date and reason for loss or discontinuation required	• Change coverage tier • Enroll eligible dependent(s) • Enroll In Coverage • Change coverage option to elect new coverage for you, you + spouse, or you + child(ren), or you + family * **Note**: For loss of Medicaid or SCHIP coverage, you have 60 days for actions above
Loss of last dependent(s) that impacts your Tier	— Provide documentation stating the reason and date eligibility was lost unless the reason for loss of coverage is because of reaching age 26	• Change coverage tier

If You Have One Of These Qualifying Events:	Provide This Documentation:	Within 31 Days Of Qualifying Event, You May / Must:
Your former spouse loses other qualified coverage, resulting in loss of your dependent child(ren)'s coverage under former spouse's plan	• Furnish Social Security Number and dependent verification for each dependent you wish to cover • Letter from other plan documenting name(s), of everyone who lost coverage, date, reason, and when coverage was lost.	• Enroll eligible dependent(s) • Enroll in Coverage for you and your eligible dependent(s) • Change coverage option to elect new coverage for you + child(ren) • Increase coverage tier
Covered Dependent loses Eligibility • Provide documentation stating the reason and date eligibility was lost unless the reason for loss of coverage is because of reaching age 26.	• No documentation required to change coverage tier for last **child who turns 26**	• Change coverage tier to remove ineligible spouse and/or dependent(s) • Change coverage option to elect new coverage for you, you + spouse, you + child(ren) or you + family
Gain of coverage due to other employer's open enrollment **Note**: Plan year can be the same, but Open Enrollment dates must be different	• Letter from other employer documenting name(s) of everyone who gained coverage, date, reason, and when coverage was gained	• Change coverage tier to remove spouse and/or dependent(s) • Change coverage option to elect new coverage for you, you + spouse, or you + child(ren) • Discontinue coverage
Loss of coverage due to other employer's open enrollment **Note**: Plan year can be the same, but Open Enrollment dates must be different	• Furnish Social Security Number for each dependent you wish to cover • Letter from other employer documenting name(s) of everyone who lost coverage, date, reason, and when coverage was lost	• Enroll eligible dependent(s) • Enroll In Coverage • Change coverage option to elect new coverage for you, you + spouse, or you + child(ren), or you + family • Change coverage tier

If You Have One Of These Qualifying Events:	Provide This Documentation:	Within 31 Days Of Qualifying Event, You May / Must:
You or your spouse acquire new coverage under spouse's employer's plan	• Letter from other plan documenting your effective date of coverage and names of covered dependents	• Change tier to you coverage • Discontinue coverage – you must document that all members removed from the SHBP coverage are covered under the other employer's plan • Change coverage option to elect new coverage for you, or you + child(ren)
Your spouse or your only enrolled dependent's employment status changes, resulting in a gain of coverage under a qualified plan other than from SHBP	• Letter from other employer documenting coverage enrollment required, and • Everyone removed from coverage under the SHBP must be enrolled in the plan. This includes coverage acquired due to the other employer's open enrollment.	• Change coverage tier to remove spouse and/or dependent(s) • Change coverage option • Discontinue coverage
You or your spouse is activated into military services	• Furnish Social Security Number and dependent verification for each dependent you wish to cover • Copy of orders required	• Enroll in coverage • Change coverage option to elect new coverage for you, you + spouse, or you + child(ren), or you + family • Change coverage tier • Discontinue coverage

If You Have One Of These Qualifying Events:	Provide This Documentation:	Within 31 Days Of Qualifying Event, You May / Must:
You retire and immediately qualify for a retirement annuity with a State Retirement System other than ERS, TRS, or PSERS	• You must complete and submit the Retiree/Surviving Spouse form no later than 60 days after leaving active employment. Automatic deductions for health coverage should start when the retiree receives his/her initial retirement check. It is your responsibility to verify that the health insurance deduction was taken from your initial retirement check.	• Change coverage tier to you • Change Option • Discontinue Coverage

Note: If your retirement system is ERS, TRS or PSERS you will automatically be enrolled in same option and tier as a retiree. You will receive a letter from SHBP advising you that the change was made and stating you have 31 days if you wish to make a change in coverage. However, if you and/or a covered dependent are enrolled in a minimum of Medicare Part B, coverage will roll over to the UHC Medicare Advantage (MA) Standard Option. The DCH, SHBP Division must have received and processed your Medicare information in order for the rollover to occur and have a street address as CMS will not approve enrollment in a MA option with a P. O. Box as your address. Please refer to the Medicare Section for more information.

You retire and immediately qualify for a retirement annuity under the Georgia ERS, TRS, or PSERS retirement system	Coverage will automatically roll to the same option and tier you had as an active employee unless you have Medicare Part B coverage. Employees or covered dependents with Medicare Part B coverage will roll to the Medicare Advantage standard option. Automatic deductions for health coverage only start when the Retiree receives his/her initial retirement check from ERS, TRS or PSERS. It is your responsibility to verify that the health insurance deduction was taken from your initial retirement check.	• Change coverage tier to you • Change Option • Discontinue Coverage

If You Have One Of These Qualifying Events:	Provide This Documentation:	Within 31 Days Of Qualifying Event, You May / Must:
	You should carefully read the *Retiree Decision Guide* and Section 5 of this SPD for additional important detailed information.	
Spouse's Loss of Eligibility for Health Insurance due to Retirement **Note**: Retirement without loss of eligibility for health insurance, discontinuation of coverage, reduction of benefits, or a change in premiums ARE NOT qualifying events.	• Letter from other employer documenting loss of coverage, date coverage ended and reason for loss is required	• Change coverage tier • Enroll eligible dependents • Lower coverage • Change Option • Discontinue coverage. • Change coverage option to elect new coverage for you + spouse, or you + child(ren), or you + family
• If you return to work as an active employee with an employing entity under the Plan, either immediately after you retire or at a later date, your retirement annuity may be suspended or continued but your health insurance must be through your active employment.	• You must complete the New Enrollment/Transfer Form	• You must elect SHBP coverage as an active employee.
• When you stop work as an active employee.	• You MUST complete the Retiree/Surviving Spouse Form to set up your deductions through the retirement system again	• Annuitant coverage may be reinstated if you notify DCH, SHBP Division within 60 days. You must have continuous coverage, based on the conditions that

If You Have One Of These Qualifying Events:	Provide This Documentation:	Within 31 Days Of Qualifying Event, You May / Must:
		first made you eligible as a retiree • Change coverage tier to You • Change Option
You, or enrolled dependents turn age 65	• Enrollment in Medicare is not required while actively working. However, once you stop working, premiums and options are based on enrollment in Medicare Part B. You will have 2 additional MA options. To receive the state subsidy, you will need to enroll in one of the MA options. You must enroll in Medicare Part B and continue to pay Part B premiums to enroll in a SHBP MA Option. A copy of your Medicare card should be submitted 30 days prior to the retirement or the month you or your covered spouse turns 65. **Note:** The SHBP Medicare Advantage Plans include Part D prescription drug coverage	**As an Active Employee** • Change coverage tiers. • If no eligible dependent(s), discontinue coverage. **As a Retiree** • Discontinue your dependent(s) coverage or drop SHBP coverage. If you discontinue your SHBP coverage when you enroll for Medicare, you won't be able to enroll again for SHBP coverage unless you return to work in a position that offers SHBP coverage. • Retirees may change to any available option upon becoming eligible for Medicare coverage but you will lose the state's contribution toward your health coverage if you do not enroll in a Medicare Advantage option at age 65 • See the Retiree Section (#5) for more information

Open Enrollment and Retiree Option Change Period

During Open Enrollment and the Retiree Option Change Period, members must answer surcharge questions and make their coverage choices for the upcoming Plan Year. If you do not take any action during Open Enrollment or the Retiree Option Change Period, you will be required to pay surcharges. See the Surcharge section of this SPD for more information. See the current *Health Plan Decision Guides* for Web addresses and instructions. If you do not have Internet access or if your request is in the middle of a Plan year, then:

- **Notify your personnel/payroll office.** If you are a former employee, contact the SHBP Call Center directly at 1-800-610-1863.
- **Return completed forms or make election on-line**. You must make your change by the appropriate deadline.

If you miss the deadline, you won't be able to make your change until the next Open Enrollment or Retire Option Change Period, or if you experience a qualifying event. Changes permitted for former employees are limited, please refer to the retiree section for more details.

General Information about When Coverage Ends

The Board of Community Health may discontinue the SHBP and/or all benefit options at any time.

Certain employers may choose to stop offering SHBP coverage to employees or take actions that cause a termination of coverage for their employees:

Local school systems may withdraw from the plan for public school employees other than teachers. That means they can stop offering SHBP coverage to employees who are eligible for the plan for other public school employees and are not eligible for the plan for teachers. See the Eligibility section for more information.

State authorities participating in the ERS may stop offering SHBP coverage to employees and retirees,

Charter schools that elected to offer SHBP coverage to employees may revoke that election through action or inaction (such as failure to pay required contributions) and thereby stop offering SHBP coverage to employees,

Employers that offer SHBP coverage to employees through a contract with DCH may stop offering SHBP coverage through action or inaction that causes the contract to terminate, and

Local school boards may stop offering SHBP coverage to school board members.

When coverage ends because the Board of Community Health discontinues the SHBP or because your employer stops offering the SHBP, this termination of coverage does not create continuation rights. However, you may have rights to continue coverage if you resign or retire while your employer still offers the Plan.

Whenever coverage ends for any reason, your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, we will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, we do not provide Benefits for health services that you receive for medical conditions that occurred after your coverage ended, even if the underlying medical condition occurred before your coverage ended.

An Enrolled Dependent's coverage ends on the date the Member's coverage ends.

Events Ending Your Coverage as an Active Employee

Coverage ends on the earliest of the dates specified in the following table:

Who:	Your Coverage Will End If:	When:
For You	• You no longer qualify under any category listed under the eligibility rules and your payroll deductions for coverage have ceased • You do not make direct pay premium payments on time • You do not submit required premiums to your employer while you are on an unpaid leave of absence • You resign or otherwise your employment ends • You are laid off because of a formal plan to reduce staff • Your hours are reduced so that you are no longer benefits eligible • You do not return to active work after an approved unpaid leave of absence • You are terminated by your employer • You intentionally misrepresent eligibility for SHBP coverage for yourself or any covered dependents • You intentionally misrepresent eligibility for waiver of the tobacco or spousal surcharge, either by failing to answer the questions	• Coverage for Member ends at the end of the month following the month in which the last premium is deducted from your earned paycheck or at the end of paid coverage. Premiums will not be deducted from final leave pay. **Note**: If an Employing Entity fails to remit Premiums or documentation or fails to reconcile bills in the manner required by the Plan, the Plan may suspend coverage for all Enrolled Members of the Employing Entity. During a period of suspended coverage, benefits will continue to be paid, but the Employing Entity will be directly responsible for reimbursing SHBP for all claims paid. If the Employing Entity fails to provide the required Premiums or documentation or reconcile bills, coverage may be terminated for all Enrolled Members of the Employing Entity. In this instance, DCH, SHBP Division will send a notice to Enrolled Members before the coverage is terminated. Although termination of coverage in

Who:	Your Coverage Will End If:	When:
	truthfully or failing to notify DCH, SHBP Division of a change to your answers during the year • Member contributions that are not remitted to the Plan by the due date may result in suspension/and or termination of coverage. • Your employer stops offering the SHBP, either by action (such as withdrawing from the plan for public school employees other than teachers) or inaction (such as not paying required contributions).	this situation does not give rise to COBRA continuation rights, members who have a right to continue coverage after resignation or retirement under State law will be provided an opportunity to do so if they stop working for the Employing Entity while SHBP coverage is in place. • Coverage will end beginning on the date that your false response is discovered and new coverage will not be available for at least 12 months thereafter.
	When Coverage May Be Continued: SHBP allows individuals to continue their SHBP coverage in certain situations when it would have otherwise ended.	
	• Leave your job with less than 8 Years of Service • Leave your job and: — Have at least 8 Years of Service	• Continue coverage for up to 18 months under COBRA provisions • Continue coverage by: — Submitting the Direct Pay Enrollment form within 60 days of when coverage would end — Pay full cost of coverage* until you start receiving an annuity under the retirement system (if applicable) — Provide statement from retirement system verifying your service

Who:	Your Coverage Will End If:	When:
		— Pay annuitant premium once annuity begins if you have notified DCH, SHBP Division to start your deductions from your annuity — *Except for participants covered under the Legislative Retirement System

Note: The chart above applies for most SHBP members; certain parts of the Georgia code may stipulate other conditions for SHBP continuation. Member contributions not remitted to the Plan by the due date may result in suspension and/or termination of coverage.

For Your Dependents

- Coverage for your dependents will end at the same time you lose coverage because you are no longer eligible.
- Coverage will end for children at age 26 unless disabled prior to age 26 and the appropriate documentation has been submitted and approved by DCH, SHBP Division

* A divorced spouse or covered dependent may continue Plan coverage by electing COBRA continuation coverage, which is limited to 36 months of coverage. The dependent must request COBRA coverage from the DCH, SHBP Division within 60 days of the qualifying event.

** **Discontinuation of coverage for a spouse or other covered dependent(s) during Open Enrollment does not qualify as a COBRA event. In order for a spouse or other dependent(s) to be eligible for continuation of coverage under COBRA, the DCH, SHBP Division must be notified at the time the divorce is final. If a spouse's coverage is discontinued during Open Enrollment in anticipation of divorce, the former spouse may be able to elect COBRA coverage when the divorce is final.**

Section 5: Eligibility as a Former Employee with 8 or more Years of Service or as an Annuitant: When coverage as a Former Employee or Annuitant Begins and Ends

Note: This Section does not apply to individuals who have less than eight years of service with a state retirement system or who are eligible because they work for an entity that has joined the SHBP through a contract with DCH. The terms of the contract control. This SPD does not contain specific information about how much former employees and annuitants are required to pay for continuation coverage. Premium rates are set by the Board of Community Health, usually on an annual basis. Premium rates for former employees who are not annuitants usually reflect the entire cost of coverage plus an administrative fee. Premium rates for annuitants currently reflect a subsidy for certain options. The Board of Community Health is authorized to set premiums by resolution, and may change premium requirements at any time with advanced notice. The Board approved a change in the methodology for subsidizing premiums for annuitants and their dependents. The new methodology adjusts the subsidy for annuitant premiums based on Years of Service for future annuitants who had less than five Years of Service as of January 1, 2013. This change will impact employees who had less than five years of service as of January 1, 2013 when they retire with an annuity in the future. Information will be made available before annuitant premiums based on Years of Service apply to any annuitant. Current rates for active employees, former employees, annuitants are posted on the DCH website at www.dch.georgia.gov.

Plan Membership

This section includes Plan Membership, Plan options and Medicare information for enrolled annuitants and enrolled former employees as well as important points to consider if you are considering retiring with an annuity or resigning with eight or more years of service. All former employees and annuitants age 65 or older who choose to enroll in an SHPB option that is not a Medicare Advantage (MA) option will pay the full cost of SHBP coverage. See the *Retiree Decision Guide* for more information. SHBP defines an annuitant as an individual who has started drawing a monthly check from a State Retirement System. If your monthly annuity check is not large enough to pay the full premium, you may arrange with DCH, SHBP Division to make direct payments of the annuitant premium.

Disabled individuals under the age of 65 with Medicare Parts A and B have two additional Medicare Advantage options. Contact SHBP if you have been approved by Social Security for Medicare due to disability and are under the age of 65 to discuss your options and

rates. If you will be drawing an annuity you can be covered under any SHBP plan and will pay the Annuitant premium.

Retirees have certain rights that active employees do not have. Refer to Section 11 for your more information about your rights and responsibilities.

This Section is broken down by the various scenarios under which benefits may be continued.

Eligibility

8+ Years of Service with a State Retirement System (but not eligible to draw an annuity in the future) – Direct Pay

- You may continue your health insurance after active employment ends by paying the State Extended Coverage premiums directly to DCH, SHBP Division
- Your Plan options are the same as active employees unless you are age 65 and have Medicare Part B and you will then have two additional Medicare Advantage Options
- You must complete the Direct Pay Enrollment Form and remit monthly State Extended Coverage premiums to DCH, SHBP Division

8+ Years of Service (and able to draw an annuity in the future) – Direct Pay

- You may continue your health insurance after active employment ends by paying the required State Extended Coverage premiums directly to DCH, SHBP Division
- Your Plan options are the same as active employees unless you are age 65 and have Medicare Part B and you will then have two additional Medicare Advantage Options
- You must complete the Direct Pay Enrollment Form and remit monthly State Extended Coverage premiums to SHBP until you start drawing an annuity
- You must continue paying the State Extended Coverage premiums directly to DCH, SHBP Division every month until you begin drawing an annuity and are able to pay the Annuitant premiums
- When you start drawing your annuity, you will need to notify DCH, SHBP Division in order to have the premium changed from the State Extended Coverage premium to the Annuitant premium and to set up deductions from your annuity check
- You will need to confirm that the correct deduction comes out of your first annuity check
- If your annuity check is too small for the Annuitant premiums to be deducted, then you will pay the Annuitant premiums directly to DCH, SHBP Division.

Eligibility as an Annuitant

You may be able to continue Plan coverage if you are enrolled in the Plan when you retire and are immediately eligible to draw a retirement annuity from any of these State Retirement Systems:

- Employees' Retirement System (ERS)
- Teachers Retirement System (TRS)
- Public School Employees Retirement System (PSERS)
- Local School System Teachers Retirement Systems
- Fulton County Retirement System (eligible Members)
- Legislative Retirement System
- Superior Court Judges or District Attorney's Retirement System

Important Note: Individuals who withdraw all money from their respective retirement system will not be able to continue health coverage as an annuitant. Eligibility for temporary extended coverage under COBRA provisions would apply, and individuals with eight or more years of service are eligible for ongoing continued coverage as described below.

Options and Rates when Eligible to Immediately Draw an Annuity

Under Age 65

- Plan options are currently the same as for active employees
- Rates are the currently the same as for active employees
- If in ERS, TRS or PSERS Retirement Systems your coverage will automatically roll over into retirement
- If in another state retirement system, you will need to complete a Retiree/Surviving Spouse Form

Age 65+ and have Medicare Part B

- Premiums and options change at age 65.
- Plan options are currently the same as for active employees + two additional Medicare Advantage options
- If you enroll in Medicare Part B at age 65, you may enroll in one of the SHBP Standard or Premium Medicare Advantage Options (currently subsidized) OR
- You may have one of the other SHBP options but you will pay the full cost (not subsidized)
- MA options include Medicare Parts A, B and D
- The benefits paid under the MA options reflect what Medicare would have paid (except for some plan enhancements); therefore, it does not coordinate benefits with any Medicare
- If you are enrolled in a SHBP MA Option and enroll in an individual MA or Part D Plan, you may lose eligibility for SHBP coverage
- If in ERS, TRS or PSERS Retirement Systems your coverage will automatically roll over into retirement
- If in another state retirement system, you will need to complete a Retiree/Surviving Spouse Form

Split Eligibility – one person under age 65 and one person 65 or older with Medicare Part B

- Plan options are currently the same as for active employees, and, in addition, Medicare Advantage options are available to the person who purchases and maintains Medicare Part B
- If the person with Medicare Part B maintains Medicare Part B and enrolls in a Medicare Advantage option, coverage is currently subsidized, and an annuitant's dependent who is not eligible for

Medicare Part B may enroll in any non-MA option on a subsidized basis.

- If any person age 65 or older enrolls in a non-MA option, the full cost of all coverage elected must be paid – there is no subsidized coverage.
- If receiving your first check from ERS, TRS or PSERS Retirement Systems, your coverage will automatically roll over into retirement
- If DCH, SHBP Division has received and processed your Medicare Part B information, we will roll your coverage to the MA Standard under your current healthcare vendor.
- If you have dependents not eligible for the MA option, their coverage will roll to the option they had at the time you became covered by the MA option.

SHBP will continue to pay primary benefits for former employees not enrolled in a Medicare Advantage Option at age 65 or older. See the Medicare COB section as there is important information you need to know.

IMPORTANT NOTICE: The SHBP Medicare Advantage Plans include Part D prescription drug coverage.

NOTE: Individuals who have lived at least 5 years in the United States may purchase Medicare Part B coverage even if they did not contribute to Social Security or work the number of required quarters. Enrollment in Medicare Part B is required to enroll in a Medicare Advantage Option.

Applying for Coverage Continuation as an Annuitant

You must apply for continued coverage for yourself and Covered Dependents within 60 days of the date your coverage as an active employee ends. Application can be made on a Retiree/ Surviving Spouse Form, available online at www.dch.georgia.gov/shbp under forms or by contacting the Plan's Eligibility Section at (800) 610-1863. **Failure to apply on time or failure to make the correct premium payments will permanently end your SHBP coverage.** Members receiving their first monthly annuity check from ERS, TRS, and PSERS will be automatically enrolled in the same option they had as an active employee, unless Medicare Part B coverage has been reported to SHBP. Retirees with Medicare Part B coverage on file will automatically be enrolled in the Medicare Advantage Standard Option offered by the claims administrator they currently have. Currently, only the Medicare Advantage options are subsidized for annuitants over age 65 or who are eligible for Medicare Part B due to disability. The Board of Community Health establishes required premiums by resolution, and premiums may be changed at any time with advance notice.

Annuitants may request to change Plan options if the request is made within 31 days of retirement. You may request the change by downloading, printing and completing the Retiree/Surviving Spouse Form available online at www.dch.georgia.gov/shbp or you may call the SHBP Call Center at (800) 610-1863 to request a form. Currently, Plan options include the Medicare Advantage Premium Plan, Wellness and Standard High Deductible Health Plan (HDHP), Wellness and Standard Health Maintenance Organization (HMO), and Wellness and Standard Health Reimbursement Account (HRA) offered through SHBP. Annuitants who are eligible for TRICARE

may also purchase a TRICARE Supplement (not subsidized or sponsored by DCH or any employer) as an alternative to SHBP options. If you or your covered dependent is age 65 and elects to enroll in one of the non-MA options, you will pay the full cost of your coverage; there is no subsidy. The TRICARE Supplement may not be purchased by individuals with Medicare.

When Annuitant Coverage Begins

If you are eligible for a monthly annuity at the time you retire, your coverage as an annuitant starts immediately at retirement, provided that you have all required annuitant premiums deducted from your monthly annuity check or, if the check is not large enough, pay all required annuitant premiums directly to DCH, SHBP Division. NOTE: You must have continuous SHBP coverage from active employee status to annuitant status. If for some reason, there is a delay in your annuity being setup resulting in a gap of coverage, you must remit required annuitant premiums for this period in order to have health insurance as an annuitant. Once set up as an annuitant, payment must be made each month for your health insurance either through deductions from your annuity check or by sending the payment directly to DCH, SHBP Division (only allowed if the annuity check is too small). If required payments are not received on time, your coverage will be terminated with no right to reinstatement of coverage. Coverage for your dependents (if you elect to continue dependent coverage) starts on the same day that your coverage as an annuitant begins. A change from You to You + Spouse, You + Child(ren) or You + Family as a former employee is allowed only when you have a qualifying event and make the request within 31 days of the event (90 days to add newly eligible dependent child). **Note: If you discontinue coverage at the time you retire or at a later date, you will not be able to get this coverage back unless you return to work in a position that offers SHBP coverage.**

When Coverage as a Former Employee (non-Annuitant) Begins

If you elect to continue coverage as a former employee with 8 or more Years of Service, your coverage as a former employee starts immediately upon resignation, provided that you make all required State Extended Coverage premium payments on time and submit required documentation to the DCH, SHBP Division on time. If required payments are not received on time, your coverage will be terminated with no right to reinstatement of coverage. Coverage for your dependents (if you elect to continue dependent coverage) starts on the same day that your coverage as a former employee begins. A change from You to You + Spouse, You + Child(ren) or You + Family as former employee is allowed only when you have a qualifying event and make the request within 31 days of the event (90 days to add newly eligible dependent child). **Note: If you discontinue coverage at the time you resign with 8 or more Years of Service or at a later date, you will not be able to get this coverage back unless you return to work in a position that offers SHBP coverage.**

When Will Coverage as an Annuitant or Former Employee End?

For You

- My coverage will end if I choose to cancel my coverage
- My coverage will end if I am paying SHBP directly for my premiums and I stop paying
- My coverage will end if I intentionally misrepresent my eligibility or the eligibility of my dependents, or if I intentionally misrepresent my eligibility for waiver of a spousal surcharge or a

tobacco surcharge in my responses to the surcharge questions or failing to notify DCH, SHBP Division of a change to my responses that would make me ineligible for the waiver.

- My coverage may end if my former employer stops offering SHBP coverage.

For Your Dependents

Coverage for your dependents will end when:

- They are no longer eligible
- A Social Security Number is not provided by the deadline
- You change from You + Family to You coverage
- Your coverage ends
- When they are approved for coverage under PeachCare for Kids

Keep in mind that if dependents are dropped from your coverage, you will not be able to enroll them again – unless you have a qualifying event. Loss of PeachCare or TRICARE Supplement coverage is a qualifying event to add your dependent(s). The request resulting from loss of TRICARE Supplement must be made within 31 day of loss of coverage and 60 days within loss of Peachcare for Kids coverage.

If your Medicare Advantage coverage is terminated by CMS due to enrollment in another plan or failure to pay Medicare Part B premiums, the DCH, SHBP Division will enroll you in the option (Standard HMO, HDHP, HRA or Wellness HMO, HDHP, HRA) you had before if the State Extended Coverage premium is received. If your option is not offered, you will be defaulted to the standard level of the option you previously had before you enrolled in the MA PPO Plan. You will pay the total cost of coverage and will not receive any subsidy.

Continuing Dependent Coverage at Your Death (for Annuitants)

In the event of your death, your covered surviving spouse or eligible dependents should contact the applicable State Retirement System (ERS, TRS, PSERS, etc.) and the DCH, SHBP Division as soon as possible. To continue coverage, surviving spouses or eligible children must complete a Retiree/Surviving Spouse Form and send it to the DCH, SHBP Division within 60 days of your death. Continuation coverage as a surviving dependent is an alternative to COBRA coverage. For information about continuation coverage through COBRA, see Section 9.

Plan provisions vary for survivors:

If surviving spouse receives an immediate annuity from a State Retirement System

- Plan coverage may continue for the surviving spouse and any covered dependent children after your death
- Surviving spouse premiums (set by the Board of Community Health, and currently subsidized) will be deducted from the annuity
- Surviving spouse must send premium payments directly to DCH, SHBP Division if the annuity is not large enough to cover premium
- Surviving spouse's new dependents or new spouse *cannot* be added to survivor's coverage

- Surviving spouse who becomes eligible for SHBP coverage as an active employee must discontinue the surviving spouse coverage and enroll as an active employee.
- When a surviving spouse ends active employee status and returns to a surviving spouse status, the surviving spouse coverage may be reinstated after notifying DCH, SHBP Division within 31 days. The surviving spouse will be eligible to continue coverage, based on the conditions that first made him or her eligible as a surviving spouse.

If surviving child receives an immediate annuity from a State Retirement System

- Plan coverage may continue after your death
- Surviving child's premium (set by the Board of Community Health, and currently subsidized) will be deducted from the annuity
- Surviving child must send premium payments directly to DCH, SHBP Division if the annuity is not large enough to cover premium
- Surviving child's coverage will terminate when he or she no longer satisfies the definition of a dependent child
- Surviving child may not add dependents to the coverage
- Surviving child who becomes eligible for SHBP coverage as an active employee must discontinue the surviving child coverage and enroll as an active employee.
- When a surviving child ends active employee status and returns to a surviving child status, the surviving spouse child coverage may be reinstated after notifying DCH, SHBP Division within 31 days. The surviving child will be eligible to continue coverage based on the conditions that first made him or her eligible as a surviving child.

Surviving spouse does not receive an immediate annuity from a State Retirement System

- Plan coverage may continue after your death if surviving spouse was married to you at least one year before your death
- Surviving spouse must send surviving spouse premiums (set by the Board of Community Health, and currently subsidized) directly to the DCH, SHBP Division
- Coverage ends if surviving spouse remarries
- Coverage ends for surviving child if he/she does not receive an annuity and there is no surviving spouse
- Plan coverage may continue under COBRA provisions
  See Section 9 for details

Making Changes to Your Retiree Coverage (for all Former Employees and Annuitants)

You can make changes to your coverage tier only at these times:

- Within 31 days of a qualifying event
  - — You may add a dependent as long as the change is consistent with the qualifying event
  - — You have 90 days to add a newly eligible dependent child
- During the annual Retiree Option Change Period
  - — You may change your Plan option only

— Re-enrollment of yourself or your dependents is only permitted as described below.

— Adding dependents is not permitted unless you have a qualifying event as described below. You can decrease your tier at any time.

Discontinuing Your Retiree Coverage or Discontinuing Your Dependent Coverage (for all Former Employees and Annuitants)

You can discontinue coverage at any time. If you discontinue coverage you may never re-enroll in the SHBP as a former employee or annuitant unless you discontinued SHBP coverage due to enrollment in TRICARE Supplemental coverage and maintained continuous coverage under TRICARE Supplemental coverage until re-enrollment in SHBP coverage during a Retiree Option Change Period.

You may discontinue coverage for your dependents at any time. However, you may never re-enroll dependents in SHBP coverage unless you discontinued the dependent child's SHBP coverage due to enrollment of your dependent child in PeachCare for Kids and the dependent child has maintained continuous coverage under SHBP or PeachCare for Kids until re-enrollment in SHBP coverage during a Retiree Option Change Period.

Except as described above, if you discontinue SHBP coverage for yourself or your dependents, you will not be able to get the coverage back unless you return to work in a position that offers SHBP coverage.

Qualifying Events for all Former Employees and Annuitants

Examples of a qualifying event are getting married, having a baby or spouse loses eligibility for health insurance. If you experience a qualifying event, you must request a coverage change within 31 days of the qualifying event (90 days for a newly eligible dependent child) by:

- Contacting the DCH, SHBP Division directly
- Returning the necessary form(s) with any requested documentation and the dependent's Social Security Number (SSN) to the Plan by the deadline.

* Fill out the form(s) completely. The Centers of Medicare & Medicaid Services (CMS) require DCH, SHBP Division to capture the SSN for all dependents. SHBP will provide coverage for a dependent to age two without a SSN.

If you miss the deadline, you will not have another chance to make the desired change. If the deadline is met, your change will take effect on the first day of the month following the receipt of your request, unless indicated in the chart below.

*** Do not delay submitting the form requesting change, even if you are waiting on documentation. Request must be made within 31 days of qualifying event.**

If you have this qualifying event…		You may…
You retire and immediately qualify for an annuity from a State Retirement System **Coverage must be continuous from active to annuitant status**.	• You must complete and submit the Retiree Surviving Spouse form no later than 60 days after leaving active employment unless you are in one of the retirement systems listed below • Your coverage will automatically roll from active to annuitant status if in ERS, TRS, or PSERS	• Change to any available Plan option • Lower coverage tier to You, You + Spouse, or You + Child(ren) • Discontinue Coverage

If you have this qualifying event…		You may…
If your State Retirement System annuity check no longer covers the premium for your health coverage	• You will be changed to a direct pay status and the premium will include an administrative fee. You will pay DCH, SHBP Division monthly for your health coverage.	• Change to any available Plan option • Discontinue coverage • Lower coverage tier to You, You + Spouse, or You + Child(ren)
You or dependent turn 65	• You must submit a copy of the Medicare Part B enrollment of the person who turned 65. Failure to submit a copy of your Medicare Part B enrollment will result in an increase in premiums to the full cost of coverage. • A copy of the Medicare card(s) or proof of Medicare coverage should be submitted the first of the month prior to the month you or your dependent reach age 65. Enrollment in Medicare Part B is necessary to enroll in a Medicare Advantage option. Part B premiums must be paid in order to keep Medicare Advantage coverage. • Unless a request is made to enroll in the Medicare Advantage Premium Plan, the person who turns 65 will be rolled into the Medicare Advantage Standard Plan with UHC (currently subsidized for annuitants) if DCH, SHBP Division has received and processed a copy of the Medicare Part B enrollment.	• The person who turns 65 may change from the Medicare Advantage Standard Plan to the Medicare Advantage Premium Plan • The person who turns 65 may change from the Medicare Advantage Standard Plan to any non-MA Plan option, and the full cost of coverage must be paid. • **Note**: If your mailing address in SHBP records is a PO Box, CMS will not approve your enrollment into a MA Plan. You will remain in your current Plan option and must pay the full cost of coverage (without any subsidy) until you provide a Street Address and CMS approves your enrollment into a MA plan. • **Note**: You will lose your SHBP MA coverage if you enroll in an individual Medicare Advantage or Part D plan or stop paying Medicare Part B premiums once enrolled in a SHBP MA option.

If you have this qualifying event…		You may…
		DCH, SHBP Division will put you in the option (Standard HMO, HDHP, HRA or Wellness HMO, HDHP, HRA) you had before as long as the State Extended Coverage premium is received. If your option is not offered, you will be defaulted to the standard level of the option you previously had before you enrolled in the MA option and you will pay the total cost of coverage for that option.
If you are working in a benefits eligible position and are continuing to receive your annuity from a State Retirement System	• You must advise DCH, SHBP Division when you terminate your benefits eligible position or you will not have health coverage as an annuitant. • You will need to complete the Retiree/Surviving Spouse form to have your health insurance deductions taken out of your retirement check.	• You must have coverage as an active employee • You must follow the active coverage rules as long as you are working in a SHBP benefits eligible position **Note**: Once you terminate your SHBP benefits eligible position you must follow the plan rules for annuitants
Acquire dependent because of marriage, birth, adoption or Qualified Medical Child Support Order (QMCSO) approved by DCH, SHBP Division	• Within 31 days of qualifying event (90 days for a newly eligible dependent child)	• Change coverage tier to add the dependent • Change coverage option • Add your eligible dependent(s)

If you have this qualifying event…		You may…
Spouse's loss of eligibility for health insurance due to retirement **Note**: Retirement without loss of eligibility for health insurance, discontinuation of coverage, reduction of benefits, or change in premiums ARE NOT qualifying events. Loss of eligibility for health insurance at retirement is a qualifying event.	• Within 31 days of qualifying event • Provide a letter from the other plan documenting loss of coverage and reason for loss of coverage is required. You will need to furnish the Social Security Number for each dependent you wish to cover.	• Change coverage tier to add the spouse • Change coverage option • Add your eligible spouse
Spouse or enrolled dependent's employment status changes, affecting coverage eligibility under a qualified health plan	• Within 31 days of qualifying event • Provide a letter from the other plan documenting loss/gain of coverage and reason for loss of coverage is required. You will need to furnish the Social Security Number for each dependent you wish to cover.	• Change coverage tier • Change coverage option • Add your eligible dependent(s)
Divorce		• Must remove spouse from coverage • Must remove stepchildren from coverage • Change coverage tier • May change Plan option to any available Plan option

If you have this qualifying event…		You may…
You and spouse are both annuitants receiving annuity checks from State Retirement Systems and you each have annuity checks large enough to have annuitant premiums deducted		• May change at any time from You + Family coverage to each having You only coverage; a request to change to You Only for you and your spouse must be filed at the same time.
Loss of dependent(s) that impacts your Tier (i.e. loss of all eligible dependents – you may change tiers to You coverage)	• Loss of dependent that affects your current tier	• Change coverage tier
Your spouse or enrolled dependent are covered under a qualified health plan and you lose eligibility, such as through other employment, Medicaid*, State Children's Health Insurance Program (SCHIP) or Medicare	• Furnish Social Security Number and dependent verification for each dependent you wish to cover • • Letter from other employer, Medicaid, or Medicare documenting date and reason for loss or discontinuation required	• Change coverage tier • • Enroll eligible dependent(s) • • Change coverage option to elect new coverage for you, you + spouse, or you + child(ren), or you + family • * Note: For loss of Medicaid or SCHIP coverage, you have 60 days for actions above

Retiree Option Change Period (ROCP)

During the Retiree Option Change Period (ROCP), generally from mid-October to mid-November each Plan year, you can make these changes to your coverage:

- Select a new coverage option
- Change to a lower tier
- Discontinue coverage (**Note**: Re-enrollments are not allowed.)

Changes will take effect the following January 1.

In mid-April the Plan will send you a postcard where you can elect to continue to receive the ROCP packet each October through the mail. The postcard will contain the web address so you can visit the site prior to making your decision. In August, each year, SHBP will mail an announcement postcard to let you know when the upcoming ROCP will occur and when ROCP materials will be available.

To ensure that you receive the information packet, make sure the DCH, SHBP Division always has your most up to date mailing address. Mail letter notifying SHBP of new address to: SHBP, P. O. Box 1990, Atlanta, GA 30301-1990. Be sure to include the retiree's Social Security Number.

If You Return to Active Employee Status

If you choose to return to active service with an employing entity under the Plan, whether immediately after you retire with an annuity or at a later date, your retirement annuity may be suspended or continued. SHBP coverage, however, must be purchased as an active employee with payroll deduction by your employer. You will need to complete enrollment paperwork with your employer and verify the deduction stopped with the retirement system.

When you return to retired status, retiree coverage will only be reinstated after notifying the DCH, SHBP Division within 31 days if you have continued to receive your retirement annuity. You will be eligible for continuous coverage, based on the conditions that first made you eligible as a retiree.

If you retired before the initial legislative funding for a particular employee group, you will not be entitled to annuitant coverage unless the final service period qualifies you for a monthly annuity from a State Retirement System.

Special Note: Re-enrollment into retiree coverage is not automatic if you continued to receive your retirement annuity check. You must request retiree coverage within 31 days of loss of active coverage or you will lose eligibility for retiree coverage.

Medicare Coordination of Benefits for all Former Employees and Annuitants

If you enroll in a Medicare Advantage option after becoming eligible for Medicare, the Medicare Advantage plan will pay the Medicare approved benefits and any additional benefits SHBP has made to this Plan. Since this plan is a Medicare approved plan, this plan does not coordinate benefits with Medicare. If you are retired and are enrolled in a SHBP non Medicare Advantage option, SHBP will coordinate benefits with Medicare. Under Georgia law, the SHBP is required to subordinate health benefits to Medicare benefits (for non MA plans).

The chart below provides important details related to primary and secondary coverage based on your Medicare status (for you and/or your dependents that are not enrolled in a Medicare Advantage plan):

If you are retired and…	The Plan will pay…
• …age 65, consider enrolling in Medicare Parts A, B, and D two months prior to the month in which you turn 65 to maximize coverage	• Secondary benefits starting on the first day of the month in which you turn 65
• …age 65, Medicare eligible and do not enroll in Part A, Part B and Part D	• Primary benefits; however, Plan premium will increase significantly
• …age 65 or older and not entitled to Medicare (because have not lived in the U.S. for 5 years or longer)	• Primary benefits; however, Plan premium will increase significantly
• …age 65 or older and have dependents not entitled to Medicare because of age	• Primary benefits for dependents

The SHBP is not a supplemental plan to Medicare. The Plan will pay secondary benefits/coordinate benefits if retired and enrolled in Medicare and the Standard or Wellness HRA, Standard or Wellness HDHP, or Standard or Wellness HMO Option. The Plan does not pay secondary benefits with the Medicare Advantage Options.

All other Plan options pay benefits after Medicare pays benefits. That means that any Medicare coverage you or your dependents have will be the primary plan and the SHBP Plan option you have will be the secondary plan. To maximize coverage, you and your dependents should consider enrolling in Medicare Parts A, B and D two months before the month in which you turn 65. For more details about coordination of benefits with a Medicare Part D plan, see the Pharmacy Rider.

See Section 8 for information about coordination of benefits with plans other than Medicare.

Frequently asked Medicare Questions

1. Are you not yet eligible for Medicare?

   — You may elect to have coverage under any of the non-Medicare Advantage options offered by SHBP.

   — Annuitant health premiums are currently similar to those of active employees

   — Former employees with more than 8 Years of Service pay State Extended Coverage premiums

2. Are you eligible or about to be eligible for Medicare?

   — Medicare is the country's health insurance program for people age 65 or older who qualify based on Medicare eligibility rules. Medicare also covers certain people with disabilities who are under age 65 and people of any age who have permanent kidney failure. Medicare becomes your primary insurance carrier once you are covered by Medicare. You are eligible for Medicare even if you never paid into Social Security. You and/or your spouse can purchase Medicare Part B if you are a U.S. Citizen, reside in the U.S., age 65 or older (or a legal non-citizen, age 65 or older, who resides and has lived in the U.S. for at least 5 years or longer)

   — You will need to send a copy of your Medicare card (A, B or D) to SHBP at P.O. Box 1990, Atlanta, GA 30301-1990 the first of the month prior to the month in which the retiree turns 65 or becomes eligible for Medicare because of disability. Options and premiums cannot be adjusted until copies of your Medicare cards are received and the change in premium is processed by the retirement system. Delay in submission of Medicare information will result in an increase in premiums to the full cost of the non-MA coverage, with no refund of the difference in premiums.

   Due to Disability

   — If you are disabled under Social Security, you may qualify for Medicare after a waiting period

3. What if I have End Stage Renal Disease?

   — If you or your dependents are enrolled in Medicare due to End Stage Renal Disease (ESRD), you may not enroll in a Medicare Advantage option during your first 30 months of Medicare coverage because SHBP is your primary coverage. After 30 months, when Medicare becomes primary, you may enroll in one of the Medicare Advantage plans. You will need to send the SHBP a copy of the letter from Social Security advising of Medicare eligibility.

Medicare information is available at:

- www.cms.hhs.gov/medicarereform
- www.medicare.gov
- www.ssa.gov
- 1-800-669-8387 (Georgia Cares)
- 1-800-633-4227 (Medicare)

Section 6: How to File a Claim

This section provides you with information about:

- How and when to file a claim.
- If you receive Covered Health Services from a Network provider, you do not have to file a claim. We pay these providers directly.
- If you receive Covered Health Services from a Non-Network Provider, you are responsible for filing a claim and payment.

If You Receive Covered Health Services from a Network Provider

Network Providers are paid directly for your Covered Health Services in accordance with the terms of the Network agreements between UnitedHealthcare and the Network Providers. If a Network Provider bills you for any Covered Health Service, contact UnitedHealthcare. However, you are responsible for meeting the Annual Deductible and for paying Coinsurance to a Network Provider at the time of service, or when you receive a bill from the provider.

Filing a Claim for Benefits*

When you receive Covered Health Services from a Non-Network provider:

You must submit a request for payment of Benefits within 24 months following the month of service (this may also be referred to as the timely filing deadline) for Non-Network Providers. If you do not submit this information within the specified time limit the claim will not be paid. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the month of service is the date your Inpatient Stay ends. Claim forms may be obtained from myuhc.com or by contacting customer service.

*****Applies to 1) Non-Network medical claims and 2) Network and Non-Network pharmacy claims.

Medicare Part D Information

Note: You should not enroll in a Part D plan if you are enrolled in a SHBP Medicare Advantage option as this will terminate your SHBP coverage.

If you are not enrolled in Medicare Part D, and are not in one of the MA plans, you may enroll during the Medicare Open Enrollment. Enrollment this year October 15 - December 7. This open enrollment is held by the Centers for Medicare and Medicaid (CMS) and not by SHBP. In many cases, you do not need the enhanced prescription drug plan. Your individual pharmacy needs determine the level of coverage that is best for you.

Part D enrollment is only for those Medicare eligible enrollees who wish to be enrolled in one of the Standard or Wellness High Deductible Health Plan (HDHP), Health Maintenance Organization (HMO), and Health Reimbursement Account (HRA) plans.

Coordination of Pharmacy Benefits between your Prescription Drug Plan (PDP) and SHBP

- If you have a Medicare Part D plan as primary, each time you go to the pharmacy, present both your Medicare Part D and SHBP identification cards.
- When Medicare coordination of benefits occurs, you should not be responsible for more than your SHBP coinsurance for eligible charges.
- When you reach the PDP coverage gap, you should still present both identification cards and you will pay your SHBP coinsurance.
- Please note that in order to be eligible for reimbursement when coordinating pharmacy benefits with your primary insurance carrier, it is your responsibility to make sure any prescriptions subject to specific benefits rules such as notification and progression Rx receive approval before your claims may be considered for reimbursement.

Required Information

When you request payment of Benefits from us, you must provide all of the following information:

A. Member's name and address.

B. The patient's name, age and relationship to the Member.

C. The member number stated on your ID card.

D. An itemized bill from your provider that includes the following:

— Patient diagnosis

— Date of service

— Procedure code(s) and description of service(s) rendered

— Provider of service (Name, Address and Tax Identification Number)

E. The date the Injury or Sickness began.

F. A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

Payment of Benefits

Through UnitedHealthcare, we will make a benefit determination as set forth below.

You may assign your Benefits under the Plan to a non-Network provider.

UnitedHealthcare will notify you if additional information is needed to process the claim. UnitedHealthcare may request a onetime extension not longer than 15 days and will pend your claim until all information is received. Once you are notified of the extension or missing information, you then have at least 45 days to provide this information.

Benefit Determinations

Post-Service Claims

Post-Service Claims are those claims that are filed for payment of benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from UnitedHealthcare within 30 days of receipt of the claim, as long as all needed information was provided with the claim. UnitedHealthcare will notify you within this 30-day period if additional information is needed to process the claim, and may request a onetime extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, UnitedHealthcare will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Pre-Service Claims

Pre-service claims are those claims that require notification or approval prior to receiving the requested medical care. If your claim is a pre-service claim, and is submitted properly with all needed information, you will receive written notice of the pre-service claim decision from UnitedHealthcare within 15 days of receipt of the claim. If you filed a pre-service claim improperly, UnitedHealthcare will notify you of the improper filing and how to correct it within 5 days after the pre-service claim was received. If additional information is needed to process the pre-service claim, UnitedHealthcare will notify you of the information needed within 15 days after the claim was received, and may request a onetime extension not longer than 15 days and pend your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, UnitedHealthcare will notify you of the pre-determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Urgent Requests for Benefits that Require Immediate Action

Urgent requests for Benefits are those that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition could cause severe pain. In these situations:

- You will receive notice of the benefit determination in writing or electronically within 72 hours after the UnitedHealthcare receives all necessary information, taking into account the seriousness of your condition.
- Notice of denial may be oral with a written or electronic confirmation to follow within 3 days.

If you filed an urgent request improperly, UnitedHealthcare will notify you of the improper filing and how to correct it within 24 hours after the urgent request was received. If additional information is needed to process the request, UnitedHealthcare will notify you of the information needed within 24 hours after the request was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 72 hours after:

- UnitedHealthcare's receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the request appeal procedures.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Section 7: Questions, Complaints and Appeals

This section provides you with information to help you with the following:

- You have a question or concern about Covered Health Services or your Benefits.
- You have a complaint.
- How to handle an appeal that requires immediate action.
- You are notified that a claim has been denied because it has been determined that a service or supply is excluded under the Plan and you wish to appeal such determination. Appeals should be sent to the following address:

  United HealthCare Services, Inc.

  P.O. Box 30994

  Salt Lake City, Utah 84130-0994

If a request for Plan benefits is denied, either totally or partially, you or your dependents will receive a notice of denial either electronically or in writing or, in case of Urgent Care, notice is verbal and then followed by an electronic or written notification.

To resolve a question or appeal, just follow these steps:

What to Do First

If your question or concern is about a benefit determination, you may informally contact Customer Service before requesting a formal appeal. The Customer Service telephone number is shown on your ID card and on page 2 of this SPD. If the Customer Service representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described in (Section 6: How to File a Claim) you may appeal it as described below, without first informally contacting Customer Service. If you first informally contact Customer Service and later wish to request a formal appeal in writing, you should contact Customer Service and request an appeal. If you request a formal appeal, a Customer Service representative will provide you with the appropriate address of UnitedHealthcare to submit the written appeal.

If you are appealing an urgent care claim denial, please refer to the "Urgent Claim Appeals that Require Immediate Action" section below and contact Customer Service immediately.

Appeal Process – How to Appeal an Eligibility Decision

The Plan Administrator, Department of Community Health, SHBP Division has the final decision-making power for eligibility appeals.

The process for adding missing information to complete the Wellness Promise is described in the Wellness Benefit Plan Incentive section of this document. The process for appealing a determination by UnitedHealthcare that you have not completed the Wellness Promise is also set forth in that section.

If UnitedHealthcare makes a final determination that you are not eligible for the 2014 Wellness Plan Options, you may appeal this eligibility determination to the DCH, SHBP Division by following Wellness Promise appeal procedures. These procedures will be made available on the SHBP website and will be provided upon request.

IMPORTANT NOTICE
2012 Wellness Appeals
Any appeal regarding completion of the 2012 Wellness Promise must be submitted to the Department of Community Health, SHBP Division by January 31, 2013. Any appeal received after this date will be denied.

For all other eligibility appeals, you should follow the standard process set forth below.

The DCH, SHBP Division will handle all eligibility appeals. There are three steps in the appeal process:

STEP 1 – TELEPHONE REVIEW

Call the SHBP's eligibility unit and ask for a review within 90 days of the eligibility denial. If you disagree with the results of the review, you may file a written request for an Administrative Review. Contact the Eligibility Unit within 90 days of when the Plan advises you that your request cannot be approved.

Note: Any issue regarding the Plan's eligibility or participation should first be addressed to the Eligibility Unit and then through the Administrative Review process.

STEP II – ADMINISTRATIVE REVIEW

To file a request for Administrative Review, complete all applicable Sections on the Admin Review form, sign the form and send a copy of the denied action if applicable. Any additional facts or materials that are pertinent to the case should be attached and submitted with this form within 90 days of the denied action concerning your eligibility. Generally a decision is reached within 60 days of receipt unless additional information is needed.

If your claim has been denied because you were not eligible for coverage under the plan, a decision will be reached within 30 days of receipt, unless additional information is needed. Please indicate on the appeal form that your claim was denied.

STEP III – FORMAL APPEAL

If your request for Administrative Review is denied, you may file a Formal Appeal, which must be postmarked within 60 days following the date of the Administrative Review decision. To file a Formal Appeal, you must complete the applicable form and attach a copy of the decision of the Administrative Review. Instructions are on the Formal Appeal form. Generally a decision is issued within 90 days following receipt; however, the number of days may be extended by notice from the DCH, SHBP Division. The written notice of the

decision by the Committee is the final step in the administrative proceedings and will exhaust all administrative remedies.

If your claim has been denied because you were not eligible for coverage under the plan, a decision will be reached within 30 days of receipt, unless additional information is needed. Please indicate on the appeal form that your claim was denied.

Please forward all written requests for Eligibility Administrative Reviews and Formal Appeals along with a completed appeal form to: State Health Benefit Plan, Vendor Program Management Unit, and P. O. Box 1990, Atlanta, GA 30301. The appeal forms are available through your Personnel/Payroll office, website address www.dch.georgia.gov/shbp or directly from the DCH, SHBP Division. All member correspondence sent to the DCH, SHBP Division should include the enrolled member's Social Security Number (SSN) to prevent a delay in processing your request.

How to Appeal a Medical or Pharmacy Claim Determination

UnitedHealthcare is the Claim Administrator for the Plan and has sole responsibility and authority to pay medical and pharmacy claims in accordance with the Plan documents, as UnitedHealthcare interprets the Plan documents.

Note: UnitedHealthcare's decisions are based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your Physician.

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit Urgent Care appeals in writing.

This communication should include:

- The patient's name and ID number as shown on the ID card.
- The provider's name.
- The date of medical service.
- The reason you disagree with the denial.
- Any documentation or other written information to support your request.

Pre-Service and Post-Service Claim Appeals
You will be provided written or electronic notification of decision on your appeal as follows:

For appeals of pre-service claims, as defined in (Section 6: How to File a Claim), the first level appeal will be conducted and you will be notified by UnitedHealthcare of the decision within 15 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by UnitedHealthcare of the decision within 15 days from receipt of a request for review of the first level appeal decision.

For appeals of post-service claims as defined in (Section 6: How to File a Claim), the first level appeal will be conducted and you will be notified by UnitedHealthcare of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by UnitedHealthcare of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with urgent claims, see "Urgent Claim Appeals that Require Immediate Action" below.

If you are not satisfied with the first level appeal decision of UnitedHealthcare, you have the right to request a second level appeal from UnitedHealthcare. Your second level appeal request must be submitted to UnitedHealthcare in writing within 60 days from receipt of the first level appeal decision.

For all medical and pharmacy claim appeals, including pre-service and post-service claim appeals, UnitedHealthcare has the exclusive right to interpret and administer the provisions of the Plan. UnitedHealthcare's decisions are conclusive and binding.

Urgent Claim Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

The appeal does not need to be submitted in writing. You or your Physician should call UnitedHealthcare as soon as possible. UnitedHealthcare will provide you with a written or electronic determination within 72 hours following receipt by UnitedHealthcare of your request for review of the determination taking into account the seriousness of your condition.

For all medical and pharmacy claim appeals, including urgent claim appeals, UnitedHealthcare has the exclusive right to interpret and administer the provisions of the Plan.

Voluntary External Review Program

If, after exhausting the two levels of appeal, you are not satisfied with the final determination, you may choose to participate in the external review program. This program only applies if the adverse benefit determination is based on:

- clinical reasons; or
- the exclusions for Experimental or Investigational Services or Unproven Services.

The external review program is not available if the adverse benefit determination is based on explicit benefit exclusions or defined benefit limits. Contact UnitedHealthcare at the toll-free number on your ID card for more information.

Section 8: Coordination of Benefits

This section provides you with information about:

- What you need to know when you have coverage under more than one plan.
- Definitions specific to Coordination of Benefit rules.
- Order of payment rules.

Filing a Claim When Coordination of Benefits (COB) applies

You and your Covered dependents may have medical coverage under more than one non-Medicare Advantage plan. In this case, the Plans coordination of benefits (COB) provisions apply.

When the SHBP is secondary, benefits are coordinated utilizing the non-duplication rule. Non-duplication maintains the member's same benefit level, regardless of the existence of two carriers. The Plan pays only the difference between the plan's normal benefit and any amount payable by the primary plan. The member is responsible for any remaining balance. If this Plan is secondary, the allowable expense is the primary plan's Network rate. If the primary plan bases its reimbursement on reasonable and customary charges, the allowable expense is the primary plan's reasonable and customary charge. If both the primary plan and this Plan do not have a contracted rate, the allowable expense will be the greater of the two plans' reasonable and customary charges.

Non-Covered Services or items, penalties, and amounts balance billed are not part of the Allowed Amount and are the Member's responsibility.

- COB applies to group health coverage, including:
  - Government programs such as Medicare or state contracts (dual SHBP coverage)
  - Your spouse's insurance at his or her work
  - COBRA coverage
- COB does not apply to an individual policy – one for which you pay the total premium directly to the insurer.

If the 24-month timely filing limit is approaching and you have not received an explanation of benefits (EOB) from the primary plan, submit your claim(s) to the Plan without the EOB prior to the deadline. When you receive the EOB, send it to the Plan for processing, even if the deadline has passed.

For COB information that applies when you or a Covered Dependent is injured in an accident caused by another party, see *Subrogation.*

How COB Works

- When you or your dependents are covered by two group health plans, **determine which plan is the primary and which is secondary.** The primary plan is obligated to pay a claim first, which generally means that it will pay most of the expenses.
- **Submit claims to the primary plan first.** You will receive a benefit payment from that plan along with an explanation of benefits (EOB).
- **Make a copy of the EOB you received from the primary plan, attach it to a claim form and mail both to the secondary plan.** The SHBP won't pay a secondary benefit until you submit the primary plan's EOB. Indicate the name and policy number of the person who has the other coverage and that plan's group number.

If your other group coverage ends, you must report the cancellation date to Member Services in writing and include supporting documentation from the primary plan. You can get the information from your employer or from the other insurance company.

How to Tell Which Plan is Primary

Generally, a plan is primary when:

- The patient is the Member or employee
- The plan does not have coordination of benefits
- The plan is a Workman's Compensation Plan or an automobile insurance medical benefit
- The other plan is Medicare and the patient is covered under the group plan of an active employee. **Note**: Members under the age 65 may qualify for Medicare because of a covered disability or end-stage renal disease. SHBP coverage will be primary until the Medicare waiting period has been exhausted. Medicare determines the length of time the SHBP coverage is primary. Retirees should refer to the Retiree Section 5 for additional information.

*** Note** for Former Employees and Annuitants with primary coverage through Medicare: Network Providers may collect the office visits coinsurance at the time of service.

In other situations, determining which plan is primary is more complicated:

- **If the patient is a dependent child with married parents,** the plan that covers the parent whose birthday comes first in the Calendar year is primary, unless the parents are divorced. If both parents were born on the same date, the plan that has covered the parent for the longest time pays first.
- **When a plan uses the gender rule to determine the primary plan, the father's plan is primary**. If the other plan follows the gender rule, the SHBP will allow the father's plan to be primary.
- **When the patient is a dependent child whose parents are divorced,** the plan of the parent with custody pays first, except where a court decrees otherwise.
- **If the parent with legal custody has remarried:**

— The plan of the parent with legal custody pays first.

— The plan of the spouse of the parent with custody pays second.

— The plan of the parent who does not have custody pays last.

If custody is joint, the plan that covers the parent whose birthday comes first in the Calendar Year is primary.

- **When two plans cover the Member as an active employee,** the plan that has covered the employee the longest pays first.
- **For active employees versus inactive employees,** a plan that covers a person:

— As an active employee is primary over a plan that covers a person who is retired, laid off or covered under COBRA.

— As an inactive employee is primary over a plan that covers the inactive employee as the spouse of an active employee.

— As a dependent of an active employee is primary over Medicare coverage for a retiree.

If none of the rules described in this section apply, the plan that has covered the person the longest is primary.

If You Have Dual Plan Coverage

Coordination of benefits when both you and your spouse have Plan coverage as Member (i.e., when you have dual coverage) works like this:

- If one of you has family coverage and the other has single coverage, only the spouse with the single coverage has dual coverage.
- When both spouses have dual coverage, the coverage of the spouse who is the patient is primary.
- If the patient is a dependent, then the plan that covers the parent whose birthday comes first in the Calendar year is primary.

When you have dual coverage, you cannot transfer Deductibles between Plan contracts.

Note: You cannot have dual coverage with Medicare Advantage. CMS will only allow enrollment in one MA plan. If you enroll in more than one MA plan, the last plan enrolled in will terminate the current enrollment. If the terminated MA plan is with SHBP the termination will end your SHBP coverage.

Other Forms of Duplicated Benefits

- The Plan does not duplicate payments that you may receive under third-party medical payment contracts or because of any lawsuit, including malpractice litigation.
- If you receive medical payments from underwriters of a homeowner's policy, an automobile insurance policy or any other payment plan, the Plan will consider only those charges over the amounts paid by the third party(ies).
- The Plan has the right to delay your payments until it determines whether or not other parties are liable for paying your medical expenses. However, when the employee or Covered Dependent must sue to determine the parties' obligations, the Plan will not delay payment provided that you or the payee agrees to reimburse the Plan for duplicated medical payments.

Section 9: Continuation of Coverage under COBRA and During Leave

This section provides you with information about all of the following:

- Continuation of coverage under federal law (COBRA).
- Continuation of coverage during approved unpaid leaves of absence.

When Coverage may be Continued

Certain situations allow you to continue your SHBP coverage temporarily. If you have eight or more Years of Service, you may have additional rights to continue coverage. See Section 5 for important information.

Unpaid Leaves of Absence

If you are an active employee on an approved unpaid leave, you may be able to continue your current coverage for up to 12 calendar months – or longer for military leave.

Unpaid leave is available for:

- Disability/illness – more details below
- Educational instruction
- Employee's convenience
- Employer's convenience
- Family medical reasons as provided under the Family and Medical Leave Act (FMLA) – more details below
- Military duty (emergency and voluntary) – more details below
- Suspension of employment

You will have to meet certain requirements for each leave type and your personnel/payroll office can provide you with the necessary information, including premium rates and a *Request to Continue Health Benefits During Leave of Absence Without Pay* form. Also, most leave types require supporting documentation which you will supply to your employer.

You can apply for continued coverage within 31 days after starting an unpaid leave.

Continuing Coverage during Approved Disability Leave

In case you become disabled while an active employee, the Plan has provisions that may allow you to continue coverage, which are described in the table below:

Because of a disability, you have this situation:	You will be affected in this way:
• You are Totally Disabled and are on an approved disability leave OR • You return to work on a part-time basis before the end of your approved disability leave and before returning to full-time work	• You will be eligible to continue health benefits for up to 12 months • You will pay the same premium amount you paid while actively working, but you must pay premiums directly to your employer — Coverage is limited to the disability period that your Physician certifies. You must provide the applicable documentation of your disability period to your employer

If you are a disabled retired Member, see Provisions for the Eligible Retirees for more information on how your coverage may be affected.

Continuing Coverage under Family and Medical Leave Act (FMLA)

You may continue medical coverage for yourself and your dependents for up to 12 weeks after the start of your leave for specific medical and/or family medical reasons if your employer has approved your leave as FMLA leave. Forms for continuing your coverage are available from your personnel/payroll office.

During FMLA leave without pay, you will pay the same premium amount you paid while actively working, but you must send your premium payment directly to your employer. How FMLA affects your coverage depends on the circumstances involving your leave.

If you have this situation:	You will be affected this way:
• Choose not to continue coverage while on leave	• Claims will not be paid by SHBP for the period after coverage terminates and while you remain on leave. You are responsible for paying Providers. • You must resume coverage when you return to work.
• Open Enrollment period occurs while on leave	• If you continue coverage while on leave, you may change coverage as permitted during Open Enrollment • If you do not continue coverage while on leave, contact your employer

If you have this situation:	You will be affected this way:
	for Open Enrollment information
• Do not return to work after your leave ends and you have paid your premiums directly to your employer during your leave	• You may be eligible to continue your health benefits through COBRA

Continuing Coverage during Military Leave

If you are on certain kinds of military leave described by federal law, you and your dependents may continue coverage by paying the same premiums you paid while actively working. However, these premiums must be paid directly to your employer. Your employer is responsible for approving your military leave and collecting premiums from you.

You may elect to discontinue coverage while on leave. The DCH, SHBP Division will reinstate your coverage when you return to employment after military service. However, for the time period allowed by the Veteran's Administration, the Plan does not cover care for a Member's illness or injury that the Secretary of Veterans' Affairs determined was acquired or aggravated during the military leave.

If You Leave Your Job With Less than 8 Years of Service

This chart shows how your coverage would be affected if you were to leave your job with less than 8 Years of Service. Please see Section 5 for information about leaving your job with 8 or more Years of Service.

If you have this situation:	You will be affected in this way:
• Leave your job • Take another job with your employer that does not qualify you for coverage • Move to part-time status with hours below the minimum required for eligibility • Are laid off or otherwise terminated employment	• You can continue coverage for up to 18 months under COBRA provisions

See provisions for Eligible Retirees for more information about how coverage is affected when you leave your job and are immediately eligible to draw a retirement annuity.

In the Event of Your Death During Active Employment

As described below, surviving dependents may continue coverage temporarily through COBRA. Note: If your surviving enrolled dependents are able to receive a retirement plan annuity (a monthly check), see Section 5 for important information about extra rights they may have. The cost of continuing coverage as a surviving dependent with an annuity may be much lower than the cost of COBRA continuation. Surviving dependents must apply for survivor continuation coverage within ninety days of the Member's death. If a surviving dependent chooses survivor continuation coverage, he or she waives the right to continue coverage under the COBRA rules.

See Section 5 for information on survivor coverage in the event of the death of a former employee with more than 8 Years of Service.

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who was covered under the Plan on the day before a qualifying event:

- A Member.
- A Member's Enrolled Children, Step-children, or legal child.
- A Member's covered spouse.

Qualifying Events for Continuation Coverage under Federal Law (COBRA)

If the coverage of a Qualified Beneficiary would ordinarily terminate due to one of the following qualifying events, then the Qualified Beneficiary is entitled to continue coverage. The Qualified Beneficiary is entitled to elect to continue the same coverage that she or he had on the day before the qualifying event. When a Qualified Beneficiary has elected COBRA continuation coverage that the coverage can be extended due to a second qualifying event.

The qualifying events are:

A. Termination of the Member from employment with us, for any reason other than gross misconduct, or reduction of hours below the minimum hours required for eligibility, or transfer to a position for which SHBP coverage is not offered; or
B. Death of the Member; or
C. Divorce from the Member; or
D. Loss of eligibility by an Enrolled Dependent who is a child; or
E. Entitlement of the Member to Medicare benefits; or
F. The Plan Sponsor filing for bankruptcy, under Title XI, United States Code, on or after July 1, 1986, but only for a retired Member and his or her Enrolled Dependents. This is also a qualifying event for any retired Member and his or her Enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

Notification Requirements and Election Period for Continuation Coverage under Federal Law (COBRA)

The Member or other Qualified Beneficiary must notify DCH, SHBP Division within 60 days of the Member's divorce, or an Enrolled Dependent's loss of eligibility as an Enrolled Dependent. If the Member or other Qualified Beneficiary fails to notify DCH, SHBP Division of these events within the 60 day period, there is no right to continue coverage under COBRA. In addition, failure to notify DCH, SHBP Division that a dependent has lost eligibility is an intentional misrepresentation, and will be grounds for terminating coverage for the Member and the dependent.

If a Member or other Qualified Beneficiary is already continuing coverage under COBRA, the Member or other Qualified Beneficiary must notify the DCH, SHBP Division within 60 days of the birth or adoption of a child. Failure to notify the DCH, SHBP Division within the 60 day period will result in loss of the right to add the new child to the COBRA coverage.

Once DCH, SHBP Division receives notification of divorce or loss of dependent eligibility from the Member or Qualified Beneficiary, coverage will be terminated for the former spouse or dependent who lost eligibility retroactive to the end of the month in which the qualifying event occurred. A COBRA election notice will be mailed to the Member or Qualified Beneficiary. If a complete, signed election of continuation coverage is submitted to DCH, SHBP Division by the later of 60 days after the qualifying event occurs or 60 days after the Qualified Beneficiary receives the COBRA election form from SHBP, COBRA coverage will be provided upon payment of required COBRA premiums.

The initial premium due to SHBP must be paid on or before the 45th day after electing continuation.

Notification Requirements for Disability Determination or Change in Disability Status

The Member or other Qualified Beneficiary must notify DCH, SHBP Division as described under "Terminating Events for Continuation Coverage under federal law (COBRA)", subsection A. below.

The notice requirements will be satisfied by providing written notice to DCH, SHBP Division at the address stated in Attachment II to this Summary Plan Description. The contents of the notice must be such that SHBP is able to determine the covered employee and Qualified Beneficiary or Qualified Beneficiaries, the qualifying event or disability, and the date on which the qualifying event occurred.

After providing notice to the DCH, SHBP Division, the Qualified Beneficiary shall receive the continuation coverage and election notice. Continuation coverage must be elected by the later of 60 days after the qualifying event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from SHBP.

The Qualified Beneficiary's initial premium due to SHBP must be paid on or before the 45th day after electing continuation.

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Members who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Members are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or

would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If a Member qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact SHBP for additional information. The Member must contact SHBP promptly after qualifying for assistance under the Trade Act of 1974 or the Member will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

Terminating Events for Continuation Coverage under Federal Law (When COBRA Coverage Ends)

COBRA, continuation coverage under the Plan will end on the earliest of the following applicable dates:

A. Eighteen months from the date of the qualifying event, if the Qualified Beneficiary's coverage would have ended because the Member's employment was terminated or hours were reduced (i.e., qualifying event A.).

   If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at any time within the first 60 days of continuation coverage for qualifying event A then the Qualified Beneficiary may elect an additional 11 months of continuation coverage (for a total of 29 months of continued coverage) subject to the following condition: (i) notice of such disability must be provided within 60 days after the determination of the disability, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated by the Plan on the first day of the month that begins more than 30 days after the date of that determination.

B. Thirty-six months from the date of the qualifying event for an Enrolled Dependent whose coverage ended because of the death of the Member, divorce of the Member, or loss of eligibility by an Enrolled Dependent who is a child (i.e. qualifying events B., C., or D.).

C. For the Enrolled Dependents of a Member who was entitled to Medicare prior to a qualifying event that was due to either the termination of employment or work hours being reduced, eighteen months from the date of the qualifying event, or, if later, 36 months from the date of the Member's Medicare entitlement, whichever is later.

D. The date coverage terminates under the Plan for failure to make timely payment of the premium.

E. The date, after electing continuation coverage, that coverage is first obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any pre-existing condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.

F. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated

because the Plan Sponsor filed for bankruptcy, (i.e. qualifying event F.).

G. The date the entire Plan ends or the date the employer stops offering SHBP coverage.

H. The date coverage would otherwise terminate under the Plan as described in this section under the heading *Events Ending Your Coverage*.

If a Qualified Beneficiary is entitled to 18 months of continuation and a second qualifying event occurs during that time, the Qualified Beneficiary's coverage may be extended up to a maximum of 36 months from the date coverage ended because employment was terminated or hours were reduced below the minimum hours for Plan eligibility. If the Qualified Beneficiary was entitled to continuation because the Plan Sponsor filed for bankruptcy, (i.e. qualifying event F.) and the retired Member dies during the continuation period, then the other Qualified Beneficiaries also shall be entitled to continue coverage for 36 months from the date of the Member's death. Terminating events B. through G. described in this section will apply during the extended continuation period.

Continuation coverage for Qualified Beneficiaries whose continuation coverage terminates because the Member becomes entitled to Medicare may be extended for an additional period of time. Such Qualified Beneficiaries should contact the DCH, SHBP Division for information regarding the continuation period.

Section 10: General Legal Provisions

This section provides you with information about:
- General legal provisions concerning the Plan.

Plan Document

This Summary Plan Description presents an overview of your benefits. If there are discrepancies between the information in this SPD and DCH Board regulations or the laws of the state of Georgia, those regulations and laws will govern at all time.

Relationship with Providers

The relationships between SHBP, UnitedHealthcare, and Network providers are solely contractual relationships between independent contractors. Network providers are not our agents or employees; nor are they agents or employees of UnitedHealthcare. Neither we nor any of our employees are agents or employees of Network providers.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we pay Benefits for Covered Services. Network providers are independent practitioners who run their own offices and facilities. The credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. Network providers are not our employees or employees of UnitedHealthcare; nor do we have any other relationship with Network providers such as principal agent or joint venture. Neither we nor UnitedHealthcare are liable for any act or omission of any provider.

UnitedHealthcare is not considered to be an employer of the SHBP for any purpose with respect to the administration or provision of benefits under this Plan.

Your employer is solely responsible for proper classification of your employment.

UnitedHealthcare is solely responsible for timely processing of benefits.

The Plan Administrator, DCH, through the DCH, SHBP Division and your employer are jointly responsible for notifying you of the termination or modification of the Plan.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and us is that of Plan Sponsor and employee, Dependent or other classification as defined in the Plan.

Incentives to You

Sometimes UnitedHealthcare may offer incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact UnitedHealthcare if you have any questions.

Interpretation of Benefits

SHBP and UnitedHealthcare have sole and exclusive discretion to do all of the following:

- Interpret Benefits Provisions. SHBP has delegated to UnitedHealthcare the sole authority to interpret the HRA Option as necessary to pay claims.
- Interpret the other terms, conditions, limitations and exclusions of the HRA Option, including this SPD and any Riders and Amendments.
- Make factual determinations related to the HRA Option and its Benefits.

SHBP and UnitedHealthcare may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

Administrative Services

We may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Plan, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Clerical Error

If a clerical error or other mistake occurs, that error does not create a right to Benefits. These errors include, but are not limited to, providing misinformation on eligibility or Benefit coverage's or entitlements. It is your responsibility to confirm the accuracy of statements made by us or our designees, including UnitedHealthcare, in accordance with the terms of this SPD and other Plan documents.

Information and Records

At times we or UnitedHealthcare may need additional information from you. You agree to furnish us and/or UnitedHealthcare with all information and proofs that we may reasonably require regarding any matters pertaining to the Plan. If you do not provide this information when we request it, we may delay or deny payment of your Benefits.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish us or UnitedHealthcare with all information or copies of records relating to the services provided to you. We or UnitedHealthcare have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Member's enrollment form. We and UnitedHealthcare agree that such information and records will be considered confidential.

We and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Plan, we,

UnitedHealthcare, and our related entities may use and transfer the information gathered under the Plan for research and analytic purposes.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, we or UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Such designees have the same rights to this information as SHBP.

Examination of Covered Persons

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Workers' Compensation not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. If you receive a Benefit payment from the Plan for an Injury caused by a third party, and you later receive any payment for that same condition or Injury from another person, organization or insurance company, we have the right to recover any payments made by the Plan to you. This process of recovering earlier payments is called subrogation. In case of subrogation, you may be asked to sign and deliver information or documents necessary for us to protect our right to recover Benefit payments made. You agree to provide us all assistance necessary as a condition of participation in the Plan, including cooperation and information submitted as supplied by a workers' compensation, liability insurance carrier, and any medical benefits, no-fault insurance, or school insurance coverage that are paid or payable.

We shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type, for the reasonable value of services and Benefits we provided to you from any or all of the following:

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity obligated to provide benefits or payments to you.

You agree as follows:

- To cooperate with us in protecting our legal rights to subrogation and reimbursement.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions.
- To execute and deliver such documents including consent to release medical records, and provide such help (including responding to requests for information about any accident or injuries and making court appearances) as we may reasonably request from you.

- You will do nothing to prejudice our rights under this provision, either before or after the need for services or benefits under the Plan.

Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if either of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the Benefits under the Plan.

The refund equals the amount we paid in excess of the amount we should have paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits that are payable under the Plan. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Limitation of Action

If you want to bring a legal action against us or UnitedHealthcare you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against us or UnitedHealthcare.

You cannot bring any legal action against us or UnitedHealthcare for any other reason unless you first complete all the steps in the appeal process described in this document. After completing that process, if you want to bring a legal action against us or UnitedHealthcare you must do so within three years of the date you are notified of our final decision on your appeal, or you lose any rights to bring such an action against us or UnitedHealthcare.

Section 11: Your Rights and Responsibilities

Active Employee Rights and Responsibilities

Your Rights as an Employee Enrolled in Plan Coverage

As an employee enrolled in Plan coverage, you have the right to:

- Have your eligible claims paid and notifications provided in a timely manner
- Receive information about the Plan and the options available to you
- Be informed of the process for filing appeals of denied claims
- Have access to Provider information
- Review your appeal file
- Examine, without charge, all documents governing the Plan at the Plan Administrator's office
- Request copies of the above documents, in writing, from the Plan Administrator (a reasonable copy fee may apply)
- Be informed by the Plan of how to continue your coverage if it would otherwise end in certain situations

Your Rights for Continuing Group Health Plan Coverage

You have the right to continue group health plan coverage if you lose Plan coverage due to a qualifying event. In this case, you may continue health care coverage for yourself, spouse or dependents; however, you or your dependents have to pay for such coverage. Review this Summary Plan Description (SPD) and other Plan documents governing your continuation coverage rights.

Your Responsibilities as an Employee Enrolled in Plan Coverage

This is a summary of some of the important responsibilities of employees enrolled in the Plan:

- **Make proper and timely premium payments.** Premium payments for active employees must be made through salary deductions. Premium payments for employees on leave must be made directly to the employer. It's your responsibility to make sure that your employer (the State, school district, agency, etc.) is deducting the right amount from your paycheck for your option and coverage tier. When you are first hired, and later during each Open Enrollment (or Retiree Option Change Period), you will receive premium information.
- **Make accurate choices when you make your enrollment selection.** After the Open Enrollment period ends, the SHBP will make changes only when there is a documented administrative error. Any premium refund will be limited to 12 months of premiums and is payable only after the Plan receives documented evidence from the Member that the Plan had no liability for additional covered persons.

- **Answer surcharge questions truthfully and notify DCH, SHBP Division immediately if the answers to your surcharge questions change during the year.** Intentional misrepresentation in response to surcharge questions or failure to notify DCH, SHBP Division of changes to your responses to surcharge will have significant consequences. Active employees will lose State Health Benefit Plan coverage for 12 months beginning on the date that your false response or failure to notify is discovered. Retirees who intentionally misrepresent the response to the surcharge questions or fail to notify DCH, SHBP Division of changes to their responses will permanently lose their SHBP health insurance.
- **Take the time to understand how the Plan option works.** You are the manager of your health care needs and, therefore, you must take the time to understand your Plan option. You also are responsible for understanding the consequences of your decisions. Carefully review this booklet and the *Active Employee Decision Guide*. Having read the documents, you can take steps to maximize your coverage.
- **Know when and how your participation can end.** Generally, coverage ends when you no longer meet job classification or working hours requirements for eligibility or when you fail to make the proper premium payments. Coverage may also end if your employer fails to pay required contributions to the DCH, SHBP Division or if your employer decides to stop offering SHBP coverage to all employees or all employees in your job classification. For eligibility requirements and other circumstances that may result in loss of coverage, see sections 4 & 5.
- **Notify DCH, the SHBP Division if you or any of your dependents are no longer eligible for coverage** If you misrepresent eligibility information when applying for coverage, during a change in coverage or when filing for benefits, or by paying for coverage on behalf of someone who is not eligible, adverse action may be taken against you by DCH or applicable enforcement agencies. Adverse actions include, but are not limited to: terminating your coverage, collection actions for all payments improperly made as a result of the misrepresentation, and criminal prosecution.
- **Notify DCH, SHBP Division of any address change and read all information sent to you by DCH, SHBP Division.** You are responsible for reading any information we or UnitedHealthcare send to you at this address. If you are not able to review Plan information for any reason, it is your responsibility to designate a representative to act on your behalf.
- **Notify us if you have a qualifying event that can affect coverage or eligibility for coverage for you or a Covered Dependent.** If you get married, divorced or have a baby, you may want to add or delete a dependent. You must notify your payroll location within 31 days (90 days for a newborn) of the event – or you won't be able to make the change until the next Open Enrollment period. Retirees do not have an Open Enrollment period; failure to notify the Plan within 31 days of a qualified change in status (90 days for a newborn) could permanently prohibit a retiree from making the desired change.

- **Furnish the DCH, SHBP Division with information required to implement Plan provisions**. When you are required to provide certain information and documentation, failure to do so by the deadline will result in denial of requested coverage. **DCH, SHBP Division will accept late dependent verification documentation at any time during the Plan Year and coverage will be retroactive to the qualifying event date or the first of the Plan Year, whichever is later.** However, no claims will be paid until the documentation is received and approved by DCH, SHBP Division.
- **Update the DCH, SHBP Division on the status of eligible dependents.** If your dependent child is nearing age 26, and is eligible to continue coverage as a disabled dependent you are responsible for informing the Plan of his or her status within 31 days of reaching age 26. Coverage won't continue automatically after a disabled dependent turns 26 – you must request it.
- **Notify the DCH, SHBP Division of any other group coverage you have,** including Medicare coverage. You may be required to provide notification in advance or on request.

Your Employer's Responsibilities

Your employer – your department, agency or other entity – has specific responsibilities under the Plan, which includes the following:

- Properly notifying the Plan Administrator for your employment classification.
- Timely paying all required employer contribution.
- Submit any necessary documentation in a timely and efficient manner.
- Withhold proper monthly premiums and submit them, along with the bill to the Plan when due. If your employer does not send in premiums and documentation in a proper and timely manner, the Plan may suspend coverage benefit payments for the Employee.
- Assist in enrolling all eligible employees in the Plan within 31 days of hire unless the employee declines coverage. Then the declination form must be completed within 31 days of hire.
- Provide enrollment information to the Plan Administrator.
- Distribute Plan materials
- Administer the Family and Medical Leave Act (FMLA) in compliance with federal law.
- Administer Military Leave in compliance with federal law.
- Administer Leave without Pay for employees.
- Collect all required premiums for employees on unpaid leave.
- If an employee was reinstated to employment for a period of time inclusive of the applicable Open Enrollment period, the employee shall be offered the opportunity to enroll or change coverage within fifteen (15) days of the return to working.
- Provide you with information on how you can continue coverage under the FMLA and under state leave without pay provisions.
- Provide necessary termination of coverage information to the Plan Administrator within 30 days after your employment ends or your eligibility for Plan Membership ends.
- Notify enrolled employees of Plan amendments or termination.

- Notify enrolled employees of the employer's decision to stop offering SHBP coverage to all or some of its employees.

Assistance With Your Questions

If you have any questions about your rights and responsibilities under this Plan, you should contact the Plan's Eligibility Unit at 800-610-1863.

Former Employee and Annuitant Rights and Responsibilities

Your Rights as a Former Employee and Annuitant Enrolled in Plan Coverage

As a Former Employee and Annuitant enrolled in Plan coverage, you have the right to:

- Have your eligible claims paid and notifications provided in a timely manner
- Receive information about the Plan and the options available to you
- Be informed of the process for filing appeals of denied claims
- Have access to Provider information
- Review your appeal file
- Examine, without charge, all documents governing the Plan at the Plan Administrator's office
- Request copies of the above documents, in writing, from the Plan Administrator (a reasonable copy fee may apply)
- Be informed by the Plan of how to continue your coverage if it would otherwise end in certain situations

Your Rights for Continuing Group Health Plan Coverage

You have the right to continue group health plan coverage if you lose Plan coverage due to a qualifying event. In this case, you may continue health care coverage for yourself, spouse or dependents; however, you or your dependents may have to pay for such coverage. Review this Summary Plan Description (SPD) and other Plan documents governing your continuation coverage rights.

Your Responsibilities as a Former Employee or Annuitant Enrolled in Plan Coverage

As a former employee or annuitant enrolled in Plan coverage, you can receive the most value from your coverage if you fulfill the following responsibilities:

- **Make proper and timely premium payments.** Premium payments usually are made through 1) the state retirement system for retirees who receive an annuity or 2) by paying directly to SHBP. Coverage must be continuous. If payment is not made for coverage each month, coverage will be terminated with no right to reinstatement.
- **Take the time to understand how the Plan option works.** You are the manager of your health care needs and, therefore, you must take the time to understand your Plan option. You also are responsible for understanding the consequences of your decisions. Carefully review this booklet and the *Retiree Health Plan Decision Guide*. Having read the documents, you can take steps to maximize your coverage.

- **Answer surcharge questions truthfully and notify DCH, SHBP Division immediately if the answers to your surcharge questions change during the year.** Intentional misrepresentation in response to surcharge questions or failure to notify DCH, SHBP Division of changes to your responses to surcharge will have significant consequences. Former employees and annuitants who intentionally misrepresent the response to the surcharge questions or fail to notify DCH, SHBP Division of changes to their responses will permanently lose their SHBP health insurance.
- **Notify DCH, SHBP Division if you or any of your dependents are no longer eligible for coverage.** If you misrepresent eligibility information when applying for coverage, during a change in coverage or when filing for benefits, or by paying for coverage on behalf of someone who is not eligible, adverse action may be taken against you by DCH or applicable enforcement agencies. Adverse actions include, but are not limited to: terminating your coverage, collection actions for all payments improperly made as a result of the misrepresentation, and criminal prosecution.
- **Notify DCH, SHBP Division of any address change and read all information sent to you by DCH, SHBP Division.** You are responsible for reading any information we or UnitedHealthcare send to you at this address. If you are not able to review Plan information for any reason, it is your responsibility to designate a representative to act on your behalf.
- **Notify DCH, SHBP Division if you have a qualifying event that can affect coverage or eligibility for coverage for you or a Covered Dependent.** If you get married, divorced or have a baby, you may want to add or delete a dependent. Former employees and annuitants do not have an Open Enrollment period; failure to notify DCH, SHBP Division within 31 days (90 days for a newborn) of a qualified change in status could permanently prohibit a former employee or annuitant from making the desired change.
- **Furnish DCH, SHBP Division with information required to implement Plan provisions**. When you are required to provide certain information and documentation, failure to do so by the deadline will result in denial of requested coverage. For example, if you do not make the request to add a new child within 31 days of the qualifying event (90 days for a newborn), your request for coverage of the new child will be denied.
- **DCH, SHBP Division will accept late dependent verification documentation at any time during the Plan Year and coverage will be retroactive to the qualifying event date or the first of the Plan Year, whichever is later.** However, no claims will be paid until the documentation is received and approved by SHBP.
- **Notify the DCH, SHBP Division of any other group coverage you have,** including Medicare coverage. You may be required to provide notification in advance or on request.

Assistance With Your Questions

If you have any questions about your rights and responsibilities under this Plan, you should contact the Plan's Eligibility Unit 800-610-1863.

Section 12: Department of Community Health, State Health Benefit Plan Notices

HIPAA Privacy Notice

State Health Benefit Plan Information Privacy Notice

Revised October 1, 2013

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Questions? Call 404-656-6322 (Atlanta) or 800-610-1863 (outside of Atlanta).

The DCH and the State Health Benefit Plan Are Committed to Your Privacy. The Georgia Department of Community Health (DCH) sponsors and runs the State Health Benefit Plan (the Plan). We understand that your information is personal and private. Some DCH employees and companies hired by DCH collect your information to run the Plan. The information is called "Protected Health Information" or "PHI." This notice tells how your PHI is used and shared. We follow the information privacy rules of the Health Insurance Portability and Accountability Act of 1996, ("HIPAA").

Only Summary Information is Used When Developing and Changing the Plan. The Board of Community Health and the Commissioner of the DCH make decisions about the Plan. When making decisions, they review reports that explain costs, problems, and needs of the Plan. These reports never include information that identifies any person. If your employer is allowed to leave the Plan entirely, or stop offering the Plan to a portion of its' workforce, DCH will provide Summary Health Information (as defined by federal law) for the applicable portion of the workforce, This Summary Health Information does not contain names, dates or birth or other identifiers, and may only be used by your employer to obtain health insurance quotes from other sources and make decision about whether to continue to offer the Plan. .

Plan Enrollment Information and Claims Information is Used in Order to Run the Plan. PHI includes two kinds of information. "Enrollment Information" includes 1) your name, address, and Social Security number; 2) your enrollment choices; 3) how much you have paid in premiums; and 4) other insurance you may have. This Enrollment Information is the only kind of PHI your employer is allowed to see. "Claims Information" includes information your health care providers send to the Plan. For example, it may include bills, diagnoses, statements, X-rays or lab test results. It also includes information you send to the Plan. For example, it may include your health questionnaires, enrollment forms, leave forms, letters and recorded telephone calls. Lastly, it includes information about you that is created by the Plan. For example, it includes payment statements and checks to your health care providers.

Your PHI is Protected by Law. Employees of the DCH and employees of outside companies hired by DCH to run the Plan are

"Plan Representatives." They must protect your PHI. They may only use it as allowed by HIPAA.

The DCH Must Make Sure the Plan Complies with HIPAA. As Plan sponsor, the DCH must make sure the Plan complies with HIPAA. We must give you this notice. We must follow its terms. We must update it as needed. The DCH is the employer of some Plan Members. The DCH must name the DCH employees who are Plan Representatives. No DCH employee is ever allowed to use PHI for employment decisions.

Plan Representatives Regularly Use and Share your PHI in Order to Pay Claims and Run the Plan. Plan Representatives use and share your PHI for payment purposes and to run the Plan. For example, they make sure you are allowed to be in the Plan. They decide how much the Plan should pay your health care provider. They also use PHI to help set premiums for the Plan and manage costs, but they are never allowed to use genetic information for these purposes. Some Plan Representatives work for outside companies. By law, these companies must protect your PHI. They also must sign "Business Associate" agreements with the Plan. Here are some examples of what they do:

Claims Administrators: Process all medical and drug claims; communicate with Members and their health care providers; and give extra (assistance) to Members with some health conditions.

Data Analysis, Actuarial Companies: Keep health information in computer systems, study it, and create reports from it.

Attorney General's Office, Auditing Companies, Outside Law Firms: Provide legal and auditing help to the Plan.

Information Technology Companies: Help improve and check on the DCH information systems used to run the Plan.

Some Plan Representatives work for the DCH. By law, all employees of the DCH must protect PHI. They also must get special privacy training. They only use the information they need to do their work. Plan Representatives in the SHBP Division work full-time running the Plan. They use and share PHI with each other and with Business Associates in order to help pay claims and run the Plan. In general, they can see your Enrollment Information and the information you give the Plan. A few can see Claims Information. DCH employees outside of the SHBP Division do not see Enrollment Information on a daily basis. They may use Claims Information for payment purposes and to run the Plan.

Plan Representatives May Make Special Uses or Disclosures Permitted by Law. HIPAA has a list of special times when the Plan may use or share your PHI without your authorization. At these times, the Plan must keep track of the use or disclosure.

To Comply with a Law, or to Prevent Serious Threats to Health or Safety: The Plan may use or share your PHI in order to comply with a law, or to prevent a serious threat to health and safety.

For Public Health Activities: The Plan may give PHI to government agencies that perform public health activities. For Research Purposes: Your PHI may be given to researchers for a research project approved by a review board. The review board must review the research project and its rules to ensure the privacy of your information.

Plan Representatives Share Some Payment Information with the Employee. Except as described in this notice, Plan Representatives are allowed to share your PHI only with you, and with your legal personal representative. However, the Plan may inform the employee family member about whether the Plan paid or denied a claim for another family member.

You May Authorize Other Uses of Your PHI. You may give a written authorization for the Plan to use or share your PHI for a reason not listed in this notice. If you do, you may take away the authorization later by writing to the contact below. The old authorization will not be valid after the date you take it away.

You Have Privacy Rights Related to Plan Enrollment Information and Claims Information that Identifies You.

Right to See and Get a Copy your Information, Right to Ask for a Correction: Except for some reasons listed in HIPAA, you have the right to see and get a copy of information used to make decisions about you. If you think it is incorrect or incomplete, you may ask the Plan to correct it.

Right to Ask for a List of Special Uses and Disclosures: You have the right to ask for a list of special uses and disclosures that were made after April 2003.

Right to Ask for a Restriction of Uses and Disclosures, or for Special Communications: You have the right to ask for added restrictions on uses and disclosures. You also may ask the Plan to communicate with you in a special way.

Right to a Paper Copy of this Notice, Right to File a Complaint without Getting in Trouble: You have the right to a paper copy of this notice. Please contact the SHBP HIPAA Privacy Unit or print it from www.dch.ga.gov. If you think your privacy rights have been violated, you may file a complaint. You may file the complaint with the Plan and/or the Department of Health and Human Services. You will not get in trouble with the Plan or your employer for filing a complaint.

Addresses for Complaints:

SHBP HIPAA Privacy Unit

P.O. Box 1990, Atlanta, Georgia 30301

404-656-6322 (Atlanta) or 800-610-1863 (outside Atlanta)

U.S. Department of Health & Human Services, Office for Civil Rights
Region IV Atlanta Federal Center 61 Forsyth Street SW, Suite 3B70 Atlanta, GA 30303-8909

Election to be Exempt from Certain Requirements of HIPAA

October 1, 2012

TO: All Members of the State Health Benefit Plan who are not Enrolled in a Medicare Advantage Option

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must comply with a number of requirements. Under HIPAA, state health plans that are "self-funded" may "opt out" of some of these requirements by making a yearly election to be exempt. Your plan option is self-funded because the Department of Community Health pays all claims directly instead of buying a health insurance policy.

Temporary rules implementing the Mental Health Parity and Addiction Equity Act apply January 1, 2012, unless the Department of Community Health again elects to be exempted from this law's requirements. The temporary rules generated more than 4,000 comments; no final rules addressing these comments have been issued. The Department of Community Health has determined to exempt your State Health Benefit Plan ("SHBP") option from the

Mental Health Parity and Addiction Equity Act, and the temporary rules' requirements, for the 2012 calendar year.

> Parity in the application of certain limits to mental health benefits. Group health plans (of employers that employ more than 50 employees) that provide both medical and surgical benefits and mental health or substance use disorder benefits must ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applicable to substantially all medical and surgical benefits covered by the plan.

The exemption from these federal requirements will be in effect for the plan year starting January 1, 2013, and ending December 31, 2013. The election may be renewed for subsequent plan years.

HIPAA also requires the SHBP to provide covered employees and dependents with a "certificate of creditable coverage" when they cease to be covered under the SHBP. There is no exemption from this requirement. The certificate provides evidence that you were covered under the SHBP, because if you can establish your prior coverage, you may be entitled to certain rights to reduce or eliminate a preexisting condition exclusion if you join another employer's health plan, or if you wish to purchase an individual health insurance policy

Section 13: Glossary of Defined Terms for this HRA Option

This section:

- Defines the terms used throughout this SPD.
- Is not intended to describe Benefits.

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance Use Disorder Services on an outpatient or inpatient basis.

Amendment - any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when signed by SHBP and UnitedHealthcare. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that are specifically amended.

Annuity – is the monthly retirement check that an individual receives who has met the requirements of a state sponsored Retirement System.

Annuitant – an individual who is enrolled in the Plan at the time he/she retires and is immediately eligible to draw a retirement annuity from a State of Georgia sponsored Retirement Systems

Annuitant Premiums – is the health premium that is deducted from the retirement check that retirees who are enrolled in the Plan and are drawing a retirement annuity from a State of Georgia sponsored Retirement Systems. Currently this premium is the same as an active employee.

Annual Deductible - the amount of Eligible Expenses you must pay for Covered Health Services in a Plan year before the Plan will begin paying for Benefits in that Plan year. This Plan has a Network Deductible and an Out-of-Network Deductible.

See the definition of Eligible Expenses below.

Autism Spectrum Disorders – a group of neurobiological disorders that includes *Autistic Disorder, Rhett's Syndrome, Asperger's Disorder, Childhood Disintegrated Disorder, and a Pervasive Development Disorders Not Otherwise Specified (PDDNOS).*

Benefits - your right to payment for Covered Health Services that are available under the Plan. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Plan, including this SPD and any attached Riders and Amendments.

Claims Administrator - the company (including its affiliates) that provides certain claim administration services for the Plan. UnitedHealthcare (also known as United HealthCare Services, Inc.) is the Plan's Claims Administrator.

Clinical Cancer Trial Services - clinical trials study the effectiveness of new interventions. There are different types of cancer clinical trials such as:

- prevention trials;
- early detection trials;
- treatment trials to test new therapies in individuals who have cancer;
- quality of life studies;
- studies to evaluate ways of modifying cancer-causing behaviors.

Clinical trials follow strict scientific guidelines that deal with many areas such as:

- study design,
- who can be in the study,
- the kind of information individuals in the study must be given when they decide to participate.

Clinical trials follow protocols for determining:

- the number of members;
- what drugs members will take;
- what medical tests they will have; and
- how often and what information will be collected.

There are four phases of clinical trials. Clinical trials pilot program will include all phases of clinical trials, as long as they meet the criteria defined for the program.

Phase I Trials evaluate how a new drug should be administered and enroll only a small number of patients.

Phase II Trials provide preliminary information about how well a new drug works and generates more information about safety and benefits of the new drug or procedure.

Phase III Trials compare a promising new drug, a combination of drugs or a procedure with the current standard. This phase involves large numbers of people in doctors' offices, clinics and cancer centers. (Many of our members will be in this category). This phase utilizes a randomized process of assigning members to the standard intervention or the trial intervention.

Phase IV Trials continue the evaluation of drugs after FDA approval and utilize drugs already on the market and available for general use.

Congenital Anomaly - a physical developmental defect that is present at birth, and is identified within the first twelve months of birth.

Coinsurance - is a percentage of Eligible Expenses determined after the deductible has been satisfied.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by UnitedHealthcare on behalf of the SHBP.

Covered Health Service(s) - those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be:

- Medically Necessary;
- included in Section 1: What's Covered--Benefits, described as a Covered Health Service;
- provided to a Covered Person who meets the Plan's eligibility requirements, as described under Eligibility in Section 4, Introduction; and

- not identified under Section 2: What's Not Covered--Exclusions, including Experimental or Investigational Services and Unproven Services.

Covered Person - either the Enrolled Member or an Enrolled Dependent, but this term applies only while the person is enrolled under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

Custodial Care - services that:

- Are non-health related services, such as assistance in activities of daily living (including but not limited to feeding, dressing, bathing, transferring and ambulating); or
- Are health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing; or
- Do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dependent –a person who meets all dependent eligibility requirements as a result of his or her relationship with an Enrolled Member.

Designated Facility - a facility that has entered into an agreement with the Claims Administrator or with an organization contracting on behalf of the Plan, to provide Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area.

To be considered a Designated Facility, a facility must meet certain standards of excellence and have a proven track record of treating specified conditions.

Direct Pay - is the monthly premium that individuals whom meet the eligibility requirements to continue coverage and pay directly to SHBP (8+ years of service or more). Premiums must be paid directly to DCH, SHBP Division when continuing health insurance after active employment ends.

Durable Medical Equipment - medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable, except urinary catheters and ostomy supplies.
- Is manufactured and used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use in the home.

Eligible Expenses - for Covered Health Services incurred while the Plan is in effect, Eligible Expenses are determined as stated below:

For Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from Network Providers Eligible Expenses are the contracted fee(s) with that provider.
- When Covered Health Services are received from Out-of-Network Providers as a result of an Emergency or as otherwise arranged through UnitedHealthcare, Eligible Expenses are the billed charges, unless a lower amount is negotiated and agreed to by the Out-of-Network Provider.

- For Out-of-Network Benefits, Eligible Expenses are determined by either:
  - negotiated rates agreed to by the non-Network provider and either the Claims Administrator or one of its vendors, affiliates or subcontractors, at the discretion of the Claims Administrator, or
  - if rates have not been negotiated, then one of the following amounts:
    - 110 percent of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market, or
    - When a rate is not published by CMS for the service, Claims Administrator uses an available gap methodology to determine a rate for the service as follows –
      - For services other than pharmaceutical products, Claims Administrator uses a gap methodology that uses a relative value scale, which is usually based on the difficulty, time, work, risk and resources of the service. The relative value scale currently used is created by Ingenix. If the Ingenix relative value scale becomes no longer available, a comparable scale will be used. Claims Administrator and Ingenix are related companies through common ownership by UnitedHealth Group.
      - For Pharmaceutical Products, the Claims Administrator uses gap methodologies that are similar to the pricing methodology used by CMS, and produces fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or the Claims Administrator based on an internally developed pharmaceutical pricing resource.
    - When a rate is not published by CMS for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under CMS published rates or a gap methodology, the Eligible Expense is based on 50 percent of the provider's billed charge, except that certain Eligible Expenses for mental health and substance use disorder services are based on 80 percent of the billed charge.

The Claims Administrator updates the CMS published rate data on a regular basis when updated data from CMS becomes available. These updates are typically implemented within 30 to 90 days after CMS updates its data.

These provisions do not apply if you receive Covered Health Services from an Out-of-Network provider in an Emergency or as otherwise arranged by the Claims Administrator. In that case, Eligible Expenses are the amounts billed by the provider, unless the Claims Administrator negotiates lower rates.

For certain Covered Health Services, you are required to pay a percentage of Eligible Expenses in the form of a Coinsurance.

Eligible Expenses are subject to the Claims Administrator's reimbursement policy guidelines, which are applied in its discretion. You may request a copy of the guidelines related to your claim from the Claims Administrator.

Emergency - a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness that

- Arises suddenly and
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency.

Enrolled Member - a person who meets all eligibility requirements for the Plan as a result of his or her current or former employment, who is currently enrolled in Coverage and who has paid the necessary contribution or premium for such Coverage in the manner required by the Plan Administrator.

Experimental or Investigational Services - medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time determination is made regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use.
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trials set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

If you have a life-threatening Sickness or condition (one which is likely to cause death within one year of the request for treatment) we may, in our discretion, determine that an Experimental or Investigational Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, we must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Genetic Testing - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution, operated as required by law that is both of the following:

- Is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- Has 24 hour nursing services.

A Hospital is not primarily a place for rest, custodial care or care of the aged and is not a nursing home, convalescent home or similar institution.

HRA Option – the SHBP option administered by United Healthcare and described in this SPD.

Initial Enrollment Period - the initial period of time during which Eligible Persons may enroll themselves and their Dependents under the Plan.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Outpatient Treatment - a structured outpatient Mental Health or Substance Use Disorder treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermediate Care – Mental Health or Substance Use Disorder treatment that encompasses one the following:

- Care at a Residential Treatment Facility.
- Care at a Partial Hospitalization/Day Treatment Program.
- Care through an Intensive Outpatient Treatment Program.

Medically Necessary – healthcare services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance use disorder, condition, disease or its symptoms, that are all of the following as determined by UnitedHealthcare or its designee, within UnitedHealthcare's sole discretion. The services must be:

- in accordance with Generally Accepted Standards of Medical Practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance use disorder disease or its symptoms;
- not mainly for your convenience or that of your doctor or other health care provider; and
- not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. UnitedHealthcare reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within UnitedHealthcare's sole discretion.

UnitedHealthcare develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by UnitedHealthcare and

revised from time to time), are available to Covered Persons on www.myuhc.com or by calling the number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

Medicare - Parts A, B and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance Use Disorder Designee - the organization or individual, designated by UnitedHealthcare, that provides or arranges Mental Health Services and Substance Use Disorder Services for which Benefits are available under the Plan.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded under the Plan.

Network Provider - also referred to as "participating" when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with UnitedHealthcare or with UnitedHealthcare's affiliate to participate in UnitedHealthcare's Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. UnitedHealthcare's affiliates are those entities affiliated with UnitedHealthcare through common ownership or control with UnitedHealthcare or with its ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of UnitedHealthcare's products. In this case, the provider will be a Network Provider for the Covered Health Services and products included in the participation agreement, and an Out-of-Network Provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - Benefits for Covered Health Services that are provided by a Network Physician, Network facility or other provider who is a Network Provider with respect to those Covered Services.

Out-of-Network Benefits - Benefits for Covered Health Services that are provided by a Non-Network Physician, Non-Network facility, or a provider that is an Out-of-Network provider with respect to those Covered Health Services.

Open Enrollment Period - a period of time that follows the Initial Enrollment Period during which Eligible Persons who are Active Employees may enroll themselves and Dependents under the Plan, as determined by the DCH, SHBP Division.

Out-of-Pocket Maximum - the maximum amount of Annual Deductible and Coinsurance you are required to pay every Plan year. If you use both Network Benefits and Out-of-Network Benefits, two separate Out-of-Pocket Maximums apply. Once you reach the Out-of-Pocket Maximum for Network Benefits, Benefits for those Covered Health Services that apply to the Out-of-Pocket Maximum for Network Benefits are payable at 100% of Eligible Expenses during the rest of that Plan year. Once you reach the Out-of-Pocket Maximum for Out-of-Network Benefits, Benefits for those Covered Health Services that apply to the Out-of-Pocket Maximum for Out-of-Network Benefits are payable at 100% of Eligible Expenses during the rest of that Plan year.

Coinsurance for some Covered Health Services will never apply to the Out-of-Pocket Maximum, as specified in Section 1: What's Covered--Benefits and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached.

You are solely responsible for paying the following costs, and these costs will never apply to your Deductible or Out-of-Pocket Maximum:

- Any charges for non-Covered Health Services;
- The amount of any reduced Benefits if you don't obtain prior authorization from as described in Section 1: What's Covered--Benefits under the *Must You Obtain Prior Authorization?* column.
- Charges that exceed Eligible Expenses.

Partial Hospitalization/Day Treatment – a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Physician - any Doctor of Medicine, "M.D.", or Doctor of Osteopathy, "D.O.", who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan - the State Health Benefit Plan.

Plan Administrator - Georgia Department of Community Health, SHBP Division.

Plan Sponsor - Georgia Department of Community Health.

Preventive Care or Preventive Services - A complete description of Preventive Care, with all preventive care codes is available at www.unitedhealthcareonline.com. To see the description, select the Medical & Drug Policies and Coverage Determination Guidelines and choose "Preventive Care Services." This description contains the preventive care codes that must be used in order for the treatment to be considered Preventive Care. If your physician does not use these preventive care codes, the treatment will not be considered Preventive Care and will be subject to the deductible and coinsurance provisions. Wellness exams coded as 99381-99387, 99391-99397, 99401-99404 and 99411-99412 will always be paid as preventive care. However, services provided during a wellness exam that are not coded as preventive care will not be considered preventive care. **Please review the complete description of preventive coverage that includes the required preventive care codes, and discuss with your physician before your appointment how he or she will code your treatment.**

In summary, preventive care services provided in an outpatient setting by health care professionals (physicians, alternative facility, hospitals) are medical services proven to have beneficial health outcomes and to be safe and effective in early disease detection or disease prevention. Under applicable laws, preventive care services require evidence-based medicine; services rated " A" or " B " by the United States Preventive Services Task Force; Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention immunization recommendations; and Health Resources and Services Administration supported evidence-informed preventive care and screenings.

Certain medical services can be done for preventive or diagnostic reasons. In general, preventive services are those performed on a person who: 1. has not had the preventive screening done before and does not have symptoms or other abnormal studies suggesting abnormalities; or 2. has had screening done within the

recommended interval with the findings considered normal; or 3. has had diagnostic services results that were normal after which the physician recommendation would be for future preventive screening studies using the preventive services intervals; or 4. has a preventive service done that results in a therapeutic service done at the same encounter and as an integral part of the preventive service (e.g. polyp removal during a preventive colonoscopy), the therapeutic service would still be considered a preventive service.

PREVENTIVE SERVICES	NETWORK
Well Male Visit Services	100% of Eligible Expenses for the following services ONLY, when claims are correctly coded by the physician as Preventive Care: • Preventive physical examination – once per plan year; however, the scheduling of your visit may be subject to your physician's office guidelines. • Abdominal Aortic Aneurysm Screening – once for men ages 65 through 75 who have ever smoked during their lifetime • HIV screening • High Blood Pressure screening • Syphilis screening • Diabetes screening • Cholesterol screening • Fecal Occult Blood screening • Immunizations – Diphtheria – Hepatitis – Hemophilus Influenza B – Influenza – Measles – Meningococcal – Mumps – Rubella – Pertussis (Whooping Cough) – Polio – Pneumococcal conjugate – Rotavirus – Tetanus – Varicella (Chicken Pox) – Zoster (Shingles) – age 60 and over • Prostate Cancer screening • Alcohol Misuse screening • Depression screening • Obesity screening • Prevention of Sexually Transmitted Diseases counseling • Tobacco Use counseling • Other Laboratory testing – Basic & Comprehensive metabolic panels – General Health, Electrolyte, Renal, Thyroid and Hepatic Function panels Zostavax (Zoster-Shingles) is a preventive vaccine and covered under medical but if the doctor does not stock this injection, the service will be covered

under the pharmacy benefit, but require a Prior Authorization.	– Urinalysis – Complete Blood Count For Colorectal Cancer Screening or Preventive Colonoscopies, please see Colorectal Cancer Screening section below.
Well Woman Visit Services	100% of Eligible Expenses for the following services ONLY, when claims are correctly coded by the physician as Preventive Care: • Preventive physical examination – once per plan year; however, the scheduling of your visit may be subject to your physician's office guidelines. • HIV screening and counseling for all sexually active adults • HPV DNA testing for women age 30 and older • High Blood Pressure screening • Chlamydia Infection screening • Gonorrhea screening • Syphilis screening • Rubella screening • Screening Mammography – follow-up mammograms when a problem is detected are NOT covered at 100%. Please see the **Outpatient Surgery, Diagnostic and Therapeutic Services** section for benefits. • Cervical Cancer screening (Pap smear) • Diabetes screening • Cholesterol screening • Fecal Occult Blood screening • Osteoporosis screening (Bone Density screening) • Immunizations – Diphtheria – Hepatitis – Human Papiloma virus (HPV) – ages 9 – 26 – Hemophilus Influenza B – Influenza – Measles – Meningococcal – Mumps – Rubella – Pertussis (Whooping Cough) – Polio – Pneumococcal conjugate – Rotavirus – Tetanus – Varicella (Chicken Pox) – Zoster (Shingles) – age 60 and over • Alcohol Misuse screening • Depression screening • Obesity screening
Gardasil (HPV) and Zostavax (Zoster-Shingles) are preventive vaccines and covered under medical but if the doctor does not stock these injections they will be covered under the pharmacy benefit, but require a Prior Authorization.	

	• Prevention of Sexually Transmitted Diseases counseling • Tobacco Use counseling • Other Laboratory testing – Basic & Comprehensive metabolic panels – General Health, Electrolyte, Renal, Thyroid and Hepatic Function panels – Urinalysis – Complete Blood Count • Voluntary Family Planning – includes diaphragms, IUD and Depo Provera and must be billed as part of the Well Woman exam. (Oral contraceptives are covered under the Pharmacy benefit and are **NOT** currently considered Preventive Care, and are NOT covered at 100 %.) For Colorectal Cancer Screening or Preventive Colonoscopies, please see Colorectal Cancer Screening section below.

Pregnant Women Preventive Services	100% of eligible expenses for the following services ONLY, when claims are correctly coded by the physician as Preventive Care: • Anemia screening • Bacteriuria screening • Hepatitis B Virus Infection screening • Rh Incompatibility screening • All other services listed under Well Woman Visit Services when a preventive physical exam is performed
Well Child Visit Services Gardasil (HPV) is a preventive vaccine and covered under medical	100% of Eligible Expenses for the following services ONLY, when claims are correctly coded by the physician as Preventive Care: • Preventive physical examination – once per plan year; however, the scheduling of your visit may be subject to your physician's office guidelines. • Cholesterol screening • Immunizations – Diphtheria – Hepatitis – Human Papiloma virus (HPV) – girls ages 9 and up

but if the doctor does not stock these injections they will be covered under the pharmacy benefit, but require a Prior Authorization.	– Hemophilus Influenza B – Influenza – Measles – Meningococcal – Mumps – Rubella – Pertussis (Whooping Cough) – Polio – Pneumococcal conjugate – Rotavirus – Tetanus – Varicella (Chicken Pox) • Hearing screening • Autism screening • Lead screening • Tuberculosis testing • Cholesterol screening • Depression screening • Obesity screening • HIV screening • Chlamydia Infection screening • Gonorrhea screening • Syphilis screening • Prevention of Sexually Transmitted Diseases counseling • Tobacco Use counseling • Other Laboratory testing – Basic & Comprehensive metabolic panels

	– General Health, Electrolyte, Renal, Thyroid and Hepatic Function panels – Urinalysis – Complete Blood Count Additional screenings for newborns: • Hypothyroidism screening • Metabolic screening panel • Phenylketonuria screening • Sickle Cell screening
Colorectal Cancer Screening	When claims are correctly coded by the physician as Preventive Care, 100% of eligible expenses for colonoscopies and Computed Tomographic Colonographies when the person: • Has not had the preventive screening done before and does not have any symptoms or other abnormal studies suggesting abnormalities • Has had the screening done within the recommended interval with the results considered normal

	If the conditions above are met and a polyp is discovered during the first colonoscopy, removal of the polyp, and associated facility, pathology and anesthesia fees done at the same encounter are covered at 100% of eligible expenses when the claims are coded correctly. If a polyp was found and removed at a prior preventive screening colonoscopy, all future colonoscopies are considered diagnostic because the time intervals between future colonoscopies would be shortened. Please see the **Outpatient Surgery, Diagnostic and Therapeutic Services** section for benefits. If the person has symptoms or other abnormal studies suggesting abnormalities, the colonoscopy is not considered preventive. Please see the **Outpatient Surgery, Diagnostic and Therapeutic Services** section for benefits.
Examples of services that are NOT considered Preventive Care: These services are **NOT** considered preventive. Please see the **Physician Office Services** or the **Outpatient Surgery, Diagnostic and Therapeutic Services** section of your Summary Plan Description for benefits. **NOTE: This list is not all-inclusive.**	• Chest X-ray • Electrocardiogram (EKG, ECG) • Pre-operative visit for a colonoscopy • Cardiac Stress test • MRI's & CT Scans • Routine Eye examinations • Hearing tests for adults • Follow up mammograms and Pap smears when problems are detected

The following are descriptions of types of services that will be considered preventive care when properly coded as Preventive Care. Even if the care provided meets a description below, it will not be covered as Preventive Care unless your physician correctly codes the service using the preventive care codes.

Covered Preventive Care Services for Adults

- **Abdominal Aortic Aneurysm** one-time screening for men of specified ages who have ever smoked
- **Alcohol Misuse** screening and counseling
- **Aspirin** use for men and women of certain ages (for men age 45 to 79 years and for women age 55 to 79 years)*
- **Blood Pressure** screening for all adults
- **Cholesterol** screening for adults of certain ages or at higher risk
- **Colorectal Cancer** screening for adults beginning at 50
- **Depression** screening for adults

- **Type 2 Diabetes** screening for adults with high blood pressure
- **Diet** counseling for adults at higher risk for chronic disease
- **HIV** screening for all adults at higher risk
- **Immunization** vaccines for adults--doses, recommended ages, and recommended populations vary:
  - Hepatitis A
  - Hepatitis B
  - Herpes Zoster
  - Human Papillomavirus
  - Influenza
  - Measles, Mumps, Rubella
  - Meningococcal
  - Pneumococcal
  - Tetanus, Diphtheria, Pertussis
  - Varicella
- **Obesity** screening and counseling for all adults
- **Sexually Transmitted Infection (STI)** prevention counseling for adults at higher risk
- **Tobacco Use** screening for all adults and cessation interventions for tobacco users
- **Syphilis** screening for all adults at higher risk

Covered Preventive Care Services for Women, Including Pregnant Women

- **Anemia** screening on a routine basis for pregnant women
- **Bacteriuria** urinary tract or other infection screening for pregnant women
- **BRCA** counseling about genetic testing for women at higher risk
- **Breast Cancer Mammography** screenings every 1 to 2 years for women 40 and older
- **Breast Cancer Chemoprevention** counseling for women at higher risk
- **Breast Feeding** counseling and interventions to support and promote breast feeding
- **Breast Pumps, defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. Benefits are only available if breast pumps are obtained from a DME provider, Hospital or Physician.**
- **Cervical Cancer** screening for sexually active women
- **Chlamydia Infection** screening for younger women and other women at higher risk
- **Domestic Violence screening and counseling**
- **Folic Acid** supplements (containing 0.4 to 0.8 mg (400 to 800 μg) of folic acid) for women who may become pregnant
- **Gonorrhea** screening for all women at higher risk
- **Hepatitis B** screening for pregnant women at their first prenatal visit
- **Osteoporosis** screening at age 60 for women at increased risk
- **Rh Incompatibility** screening for all pregnant women and follow-up testing for women at higher risk

- **Tobacco Use** screening and interventions for all women, and expanded counseling for pregnant tobacco users
- **Syphilis** screening for all pregnant women or other women at increased risk

Covered Preventive Care Services for Children

- Alcohol and Drug Use assessments for adolescents
- Autism screening for children at 18 and 24 months
- Behavioral assessments for children of all ages
- Cervical Dysplasia screening for sexually active females
- Congenital Hypothyroidism screening for newborns
- Developmental screening for children under age 3, and surveillance throughout childhood
- Dyslipidemia screening for children at higher risk of lipid disorders
- Fluoride Chemoprevention supplements for preschool children older than 6 months of age without fluoride in their water source*.
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screening for all newborns
- Height, Weight and Body Mass Index measurements for children
- Hematocrit or Hemoglobin screening for children
- Hemoglobinopathies or sickle cell screening for newborns
- HIV screening for adolescents at higher risk
- Immunization vaccines for children from birth to age 18 doses, recommended ages, and recommended populations vary:
  - — Diphtheria, Tetanus, Pertussis
  - — Haemophilus influenzae type b
  - — Hepatitis A
  - — Hepatitis B
  - — Human Papillomavirus
  - — Inactivated Poliovirus
  - — Influenza
  - — Measles, Mumps, Rubella
  - — Meningococcal
  - — Pneumococcal
  - — Rotavirus
  - — Varicella
- **Iron** supplements for children ages 6 to 12 months at risk for anemia
- **Lead** screening for children at risk of exposure
- **Medical History** for all children throughout development
- **Obesity** screening and counseling
- **Oral Health** risk assessment for young children
- **Phenylketonuria (PKU)** screening for this genetic disorder in newborns
- **Sexually Transmitted Infection (STI)** prevention counseling for adolescents at higher risk
- **Tuberculin** testing for children at higher risk of tuberculosis
- **Vision** screening for all children

* Must obtain a prescription from your doctor and meet the age/gender requirements.

Program Earning Period – the period of time that you and your covered Spouse are eligible to earn points for completed activities that will be shown on the *UnitedHealth Personal Rewards*[SM] online scorecard. Points begin accruing:

7/1/2011 for Biometric Testing

1/1/2013 for the Health Assessment

Points stop accruing 6/30/2013. At the end of the Program Earning Period, the points you and your covered Spouse have earned will be combined to determine whether you are eligible for any of the SHBP WELLNESS Plan options offered in 2013.

Qualified Medical Child Support Order (QMCSO) – Any judgment, decree order (including approval of a settlement agreement), or National Medical Support Notice that a court of competent jurisdiction or a state agency issues and is approved by the DCH, SHBP Division as a qualified medical child support order or National Medical Support Notice. The order must provide for medical coverage for your natural child.

Residential Treatment Facility – a facility which provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and which meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Designee.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu.

— room and board;

— evaluation and diagnosis;

— counseling; and

— referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

Retiree and Retiree Coverage – Former employees who have continued SHBP coverage by paying the premiums required for annuitants (currently, the same cost as active premiums) or for former employees with eight or more Years of Service (currently the full cost of coverage) are referred to in this SPD as "retirees." All references to Retiree Coverage apply to coverage in the SHBP as a former employee or annuitant.

Retiree Option Change Period – A period during which former employees enrolled in SHBP coverage may select a new coverage option. A former employee who discontinued SHBP coverage to enroll in TRICARE supplemental coverage may re-enroll in SHBP coverage during the Retiree Option Change Period as long as he or she maintained continuous coverage under either SHBP or TRICARE supplemental coverage.

Rider - any attached written description of additional Covered Health Services not described in this SPD. Riders are effective only when signed by SHBP and are subject to all conditions, limitations and exclusions of the Plan except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service,

the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Shared Savings Program - the Shared Savings Program provides access to discounts from the provider's charges when covered services are rendered by those non-Network Providers that participate in that program. UnitedHealthcare will use the Shared Savings Program to pay claims when doing so will lower Eligible Expenses. UnitedHealthcare does not credential the Shared Savings Program providers and the Shared Savings Program providers are non-Network Providers. Accordingly, Benefits for Covered Health Services provided by Shared Savings Program providers will be paid at the Out-of-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network Providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When UnitedHealthcare uses the Shared Savings Program to pay a claim, patient responsibility is limited to Coinsurances calculated on the contracted rate paid to the provider, in addition to any required Annual Deductible.

SHBP –State Health Benefit Plan. The State Health Benefit Plan is comprised of three health insurance plans established by Georgia law: 1) a plan for State employees (O.C.G.A. § 45-18-2), 2) a plan for teachers (O.C.G.A. § 20-2-891), and 3) a plan for non-certificated public school employees (O.C.G.A. § 20-2-911). Currently, benefit options are the same under all three plans and they are usually referred to together as the State Health Benefit Plan. This HDHP Option is an option under the State Health Benefit Plan.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this SPD does not include Mental Illness or substance abuse, regardless of the cause or origin of the Mental Illness or substance abuse.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Spinal Treatment - detection or correction (by manual or mechanical means) of subluxation(s) in the body to remove nerve interference or its effects. The interference must be the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Spinal Treatment provider - a licensed Chiropractor.

Split Eligibility – when one person or more is under age 65 and one person or more than 65 or older with Medicare Part B. The under 65 individuals are covered by a non-MA option and the 65+ individuals are enrolled in a MA option.

State Extended Coverage – is the continuation of health insurance by an individual who will qualify for a retirement annuity but does not qualify for an immediate annuity due to age from a State of Georgia sponsored Retirement Systems.

State Extended Coverage Premium - is the monthly premium that individuals who meet the eligibility requirements to continue coverage and pay directly to SHBP (8+ years of service or more). Premiums must be paid directly to DCH, SHBP Division when continuing health insurance after active employment ends prior to receiving an annuity.

State Retirement System – the following are State Retirement Systems:

- Employees' Retirement System (ERS)
- Teachers Retirement System (TRS)

- Public School Employees Retirement System (PSERS)
- Local School System Teachers Retirement Systems
- Fulton County Retirement System (eligible Members)
- Legislative Retirement System
- Superior Court Judges or District Attorney's Retirement System

Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance abuse disorders that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Health Service.

Surviving Dependent - Dependent eligible to continue health insurance in the event of the SHBP member's death.

Transition of Care- Transition of care is a service that enables new enrollees to receive time-limited care for specified medical conditions from an Out-of-Network physician at the benefit level associated with Network physicians.

Transitional Care – Mental Health Services/Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangement which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

UnitedHealth Personal Rewards*SM* online Scorecard– a wellness education and incentive tool administered by UnitedHealthcare or its affiliates and made available to all Covered Persons enrolled in SHBP Wellness Plan options administered by UnitedHealthcare.

Unproven Services - services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we and UnitedHealthcare may, in our discretion, determine that an Unproven Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, we and UnitedHealthcare must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Urgent Care Center - a facility, other than a Hospital, that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Years of Service – Years of Service means years of service credited under the following State Retirement Systems:

- Employees' Retirement System (ERS)
- Teachers Retirement System (TRS)
- Public School Employees Retirement System (PSERS)
- Local School System Teachers Retirement Systems
- Fulton County Retirement System (eligible Members)
- Legislative Retirement System
- Superior Court Judges or District Attorney's Retirement System

Riders, Amendments, Notices

Outpatient Prescription Drug Rider for this HRA Option

UnitedHealthcare HRA Wellness Plan for the State Health Benefit Plan

Outpatient Prescription Drug Rider for this HRA Option

Outpatient Prescription Drug Rider for this HRA Option

This Rider to the Summary Plan Description provides Benefits for outpatient Prescription Drug Products.

Benefits are provided for outpatient Prescription Drug Products at a Network or Out-of-Network Pharmacy.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in Section 11: Glossary of Defined Terms of the Summary Plan Description and in Section 3: Glossary of Defined Terms of this Rider.

When we use the words "we," "us," and "our" in this document, we are referring to DCH, SHBP Division. When we use the words "you" and "your" we are referring to people who are Covered Persons as the term is defined in the Summary Plan Description Section 11: Glossary of Defined Terms.

NOTE: The Coordination of Benefits provision Section 8: Coordination of Benefits in the Summary Plan Description does apply to Prescription Drug Products covered through this Rider. Prescription Drug Product Benefits will be coordinated with those of any other health coverage plan as described under "Coordination of Benefits (COB)" section.

Introduction

Benefits for Outpatient Prescription Drug Products

UnitedHealthcare administers your prescription drug benefit program.

This rider will cover a detailed description about your prescription drug plan benefits supply limits; notification requirements (prior authorizations); maintenance medications; covered medications; non-covered medications; definitions of brand name medications and generic medications; and Step Therapy Program.

Benefits are available for outpatient Prescription Drug Products on the UnitedHealthcare Prescription Drug List, which meet the definition of a Covered Health Service, and are dispensed at a Network. Coinsurance or other payments you are responsible for will vary depending on the outpatient Prescription Drug Product's placement within the three tiers of the UnitedHealthcare Prescription Drug List.

Note: For the most up-to-date coverage information (including supply limits, specific notification requirements, etc.) for Prescription Drug Products that meet the definition of a Covered Health Service, you must call the Customer Care number on the back of your ID card.

Coverage Policies and Guidelines

Your UnitedHealthcare pharmacy benefit provides coverage for a comprehensive selection of prescription medications. The most commonly prescribed medications for certain conditions are named or described in the UHC Prescription Drug List (PDL). All Covered Outpatient Prescription Drug Products on the PDL are FDA-approved Prescription Drug Products.

The PDL places commonly prescribed medications for certain conditions into tiers.

Your HRA Wellness Plan will have prescription medications placed in tiers.

Prescription medications are categorized within three tiers. Each tier is assigned a percentage with a minimum and a maximum amount, which is determined by your health plan. When you fill a prescription you pay the coinsurance based on the cost of your prescription.

Several factors are considered when deciding the placement of a medication on the UHC Prescription Drug List. Several committees contribute and evaluate the overall value of the medication to ensure an unbiased approach. Committee members are various health care professionals including pharmacists and physicians with a broad range of specialties.

The two main committees are:

Our National Pharmacy and Therapeutics (P&T) Committee evaluates clinical evidence in order to determine a medication's role in therapy and its overall clinical value. In addition, the P&T Committee reviews the relative safety and efficacy of the medication.

The UnitedHealthcare PDL Management Committee evaluates the clinical recommendations of the P&T committee as well as

pharmacoeconomic and economic information. Once a medication's clinical, pharmacoeconomic and economic value is established, our PDL Management Committee makes a tier placement decision based on the overall value of the medication.

The PDL Management Committee helps to ensure access to a wide range of affordable medications for you.

UnitedHealthcare may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur two times per Plan year on January 1 and July 1, but no more than six times per Plan year. These changes may occur without prior notice to you.

Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

Preventive Care Over-the-Counter (OTC) medications are covered as described in Preventive/ Routine Care definition in Glossary of Terms. In order for these drugs to be covered, you must obtain a prescription from your doctor and meet the age/gender requirements.

Note: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay coinsurance and other payments, as set forth on the most current Summary Plan Description. Please consult the UnitedHealthcare Prescription Drug List or access through the Internet at www.welcometouhc.com/shbp or log on www.myuhc.com, or call the Customer Care number on your ID card for the most up-to-date tier status.

Tier status and Coinsurance will not be overridden or changed

Preventive Care Medications

Preventive Care Over-the-Counter (OTC) medications are covered as described in Preventive Care definition in Glossary of Terms. In order for these drugs to be covered, you must obtain a prescription from your doctor and meet the age/gender requirements.

As part of Health Care Reform, effective January 1, 2013, contraceptive Prescription Drug products in Tier 1 are covered as Preventive Care medications at no charge to the member. For contraceptive Prescription Drug products in Tier 2 or Tier 3, the applicable copayment or coinsurance will apply.

Preventive care medications will not count towards your deductible.

Tobacco Cessation Medications

The Tobacco Cessation Telephonic Coaching program is available to Covered Persons age 18 and over to assist them to become tobacco free. Prescription and Over-The-Counter (OTC) tobacco cessation therapies (including Nicotine Replacement Therapy (NRT)) are available for one cycle of OTC or prescription medication as defined below (also defined as one cessation attempt) per plan year.. A Covered Person participating in the program must meet the following requirements: 1) Wellness Coach confirms member's program eligibility and member's program enrollment; 2) member selects a "quit date"; 3) member obtains a prescription for OTC or Prescribed NRT from their physician; 4) member calls and notifies the Wellness Coach of receipt of the prescription and the medication prescribed; and 5) member remains actively engaged with their Wellness Coach for the duration of the Tobacco Cessation Telephonic Coaching Program.

NOTE: Selected tobacco cessation medications will be covered as: 1) a onetime cycle of OTC tobacco cessation medications is available through Retail Network Pharmacy for 8-weeks therapy at no cost to

the member. A 31- day supply will be dispensed for the OTC medication. 1) fill and 1 refill and a prescription is required for coverage. 2) A onetime cycle of Prescription tobacco cessation medications is available through Retail Network Pharmacy for 12-weeks of therapy. The applicable pharmacy coinsurance will apply. A 31- day supply will be dispensed for the Prescription medications; 1 fill and 2 refills.

You and your covered dependents 18 years of age or older are allowed to enroll in the coaching program as many times as you like or feel you need. For the medication coverage portion of this program, the SHBP will pay for one cycle of Over The Counter (OTC) tobacco cessation medication or one cycle of Prescription tobacco cessation medication. If additional cycles of tobacco cessation medications over the allowed one medication attempt covered by the SHBP within the plan year is requires please note this will be covered at your own expense. Please call UnitedHealthcare Telephonic Health Coaching @ 1-800-478-1057 to enroll in the Tobacco Cessation Program.

Identification Card (ID Card) – Network Pharmacy

In order to utilize your prescription drug benefit at a Network Pharmacy, you must show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy. If you forget your ID card, you must provide the Network Pharmacy with identifying information that can be verified during regular business hours.

If you do not show your ID card or provide verifiable information at a Network Pharmacy you will be required to pay the Full Retail Cost (Usual and Customary Charge) for the Prescription Drug Product at the pharmacy.

If you wish to seek reimbursement, you may obtain a prescription drug claim form by calling the Customer Care number on your ID card or through the Internet at www.welcometouhc.com/shbp or logging onto www.myuhc.com. The prescription drug claim form is also available in electronic format on the Department of Community Health web site: www.dch.georgia.gov/shbp. You may print a copy of the prescription drug claim form from this web site. Along with the prescription drug claim form you will need a receipt for your prescription.

You must submit a request for payment of Benefits within 24 months following the month of service (this may also be referred to as the timely filing deadline). If you do not submit this information within the specified time limit the claim will not be paid. This time limit does not apply if you are legally incapacitated.

When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when purchasing the Prescription Drug Product. The amount you are reimbursed will be based on the Prescription Drug Cost, less the required Coinsurance.

Designated Pharmacies

If you require certain Prescription drug Products, UnitedHealthcare may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, you will be required to pay the Full Retail Costs (Usual and Customary Charge) for that Prescription Drug Product.

Specialty Designated Pharmacy Network

For Specialty Prescription Drug Products, you are required to use a Specialty Designated Pharmacy. Specialty Prescription Drug Products obtained from an Out-of- -Network Pharmacy are not

eligible for coverage and you will be required to pay the Full Retail Cost for that Prescription Drug Product.

Please see the Prescription Drug Rider Glossary for definitions of Specialty Prescription Drug and Designated Pharmacy. Refer to the heading *What's Covered—Prescription Drug Benefits* within the Prescription Drug Rider for details on Specialty Prescription Drug supply limits.

Limitation on Selection of Pharmacies

If we determine that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, we may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date we notify you, we will select a single Network Pharmacy for you.

Special Programs

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication regimens. You may access information on these programs through the Internet at www.welcometouhc.com/shbp or log on www.myuhc.com or by calling Customer Care at the number on your ID card.

Member Rights and Responsibilities

As a member, you have the right to express concerns about your State Health Benefit Plan coverage and to expect an unbiased resolution of your individual issues. You have the right to submit a written appeal or inquiry regarding any concern that you may have about the Prescription Drug Program or your drug coverage.

Pharmacy Questions: 1-877-246-4189

Written appeals and inquiries related to the Prescription Drug Program should be directed to:

State of Georgia Health Benefit Plan Members

6220 Old Dobbin Lane

Columbia, MD 21045

UnitedHealthcare Disclaimer

This Summary Plan Description (SPD) summarizes the State Health Benefit Plan Prescription Drug Program. It is not intended to cover all details related to your prescription drug coverage under the State Health Benefit Plan. This Summary Plan Description (SPD) is not a contract and the benefits that are described can be terminated or amended by the Plan Sponsor according to applicable laws, rules, and regulations. Should any conflicts arise between this booklet and your official plan documents, the official plan documents will govern.

Section 1: What's Covered--Prescription Drug Benefits

We provide Benefits under the Plan for outpatient Prescription Drug Products:

- Designated as covered at the time the prescription is dispensed when obtained from a Network Pharmacy (Retail, Mail Order, or Specialty Designated Pharmacy), or when a paper claim is filed.
- Refer to exclusions in your Summary Plan Description Section 2: What's Not Covered--Exclusions and as listed in Section 2 of this Rider.

Benefits for Outpatient Prescription Drug Products

Benefits for outpatient Prescription Drug Products are available when the outpatient Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

Benefits for outpatient Prescription Drug Products are available through three types of Network pharmacies: Retail Network Pharmacies, the Mail Order (Home Delivery) Network Pharmacy, and Specialty Designated Pharmacies.

You can obtain information about Network Pharmacies by calling the toll-free number on the back of your ID card or by logging onto **www.myuhc.com**.

Active HRA Wellness Employees that enroll in the Disease Management Program for Diabetes, Congestive Heart Failure (CHF) and Asthma may qualify for an Rx Coinsurance waiver. You must contact Care Coordination to enroll.

When a Brand-name Drug Becomes Available as a Generic

When a Brand-name drug becomes available as a Generic Prescription Drug Product, the cost of the Brand-name Prescription Drug Product may change, and therefore your Coinsurance may change. You will pay the applicable Coinsurance for the Prescription Drug Product. If you request a brand name Prescription Drug Product in place of the chemically equivalent Prescription Drug Product (generic equivalent) you will pay the applicable Coinsurance in addition to Ancillary Charges.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Coinsurance payment you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that UnitedHealthcare has developed, subject to its periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at www.welcometouhc.com/shbp or log on www.myuhc.com or by calling Customer Care at the number on your ID card.

Notification (also known as Prior Authorization or Coverage Review) Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, your pharmacist, or you must notify UnitedHealthcare. The reason for notifying UnitedHealthcare is to determine whether the Prescription Drug Product, in accordance with our approved guidelines:

- Meets the definition of a Covered Health Service and
- it is not Experimental, Investigational, or Unproven Service.

UnitedHealthcare may also require you to notify them or its designee so UnitedHealthcare can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Physician.

Network Pharmacy Notification

When Prescription Drug Products are dispensed at a Network Pharmacy and require Notification, the prescribing Provider, the pharmacist, or you are responsible for notifying UnitedHealthcare. When Prescription Drug Products are dispensed at an Out of-Network Pharmacy, you or your Physician are responsible for notifying UnitedHealthcare as required.

The Prescription Drug Products requiring notification are subject to periodic review and modification. You may find out whether a particular Prescription Drug Product requires notification by consulting your Prescription Drug List through the Internet at www.welcometouhc.com/shbp or log on www.myuhc.com or by calling Customer Care at the number on your ID card. If UnitedHealthcare is not notified before the Prescription Drug Product is dispensed, the prescription is not eligible for coverage and you will be required to pay the Full Retail Cost (Usual and Customary Charge) for that prescription at the pharmacy. If UnitedHealthcare is notified within the plan year after you pay the Full Retail Cost and the Notification is approved, you may request reimbursement from UnitedHealthcare.

If you wish to seek reimbursement, you may obtain a prescription drug claim form from UnitedHealthcare by calling the Customer Care number on your ID card or through the Internet at www.welcometouhc.com/shbp or logging onto www.myuhc.com. The prescription drug claim form is also available in electronic format on the Department of Community Health web site: www.dch.georgia.gov/shbp. You may print a copy of the prescription drug claim form from this web site. Along with the prescription drug claim form you will need a receipt for your prescription or an explanation of benefits from your primary carrier (if applicable

Please note: Notification approval will be required before the claim will be considered for reimbursement. If UnitedHealthcare is notified within the plan year after you pay the Full Retail Cost and the Notification is denied, you will not be reimbursed.

Out-of-Network Pharmacy Notification or If You Do Not Present Your ID Card

When Prescription Drug Products are dispensed at an Out-of-Network pharmacy or if you do not present your ID card, Notification approval will be required within the plan year before the claim will be considered for reimbursement.

If UnitedHealthcare is notified after you pay full retail cost (Usual and Customary Charge) and the notification is approved within the plan year you may request reimbursement from UnitedHealthcare.

If you wish to seek reimbursement, you may obtain a prescription drug claim form by calling the Customer Care number on your ID card or through the Internet at www.welcometouhc.com/shbp or logging onto www.myuhc.com. The prescription drug claim form is also available in electronic format on the Department of Community Health web site: www.dch.georgia.gov/shbp. You may print a copy of the prescription drug claim form from this web site. Along with the prescription drug claim form you will need a receipt for your prescription.

When you submit a claim on this basis, you may pay more because you did not notify UnitedHealthcare before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost, less the required Coinsurance, Ancillary Charge if applicable

Benefits may not be available for the Prescription Drug Product after the documentation provided is reviewed and it is determined that the Prescription Drug Product is not a Covered Health Service or it is Experimental, Investigational or Unproven.

Please note: Notification approval will be required before the claim will be considered for reimbursement. If UnitedHealthcare is notified within the plan year after you pay the Full Retail Cost and the Notification is denied, you will not be reimbursed

Step Therapy Program Requirements

Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Rider or Pharmaceutical Products for which Benefits are described in your Summary Plan Description (SPD) are subject to Step Therapy program requirements (also known as step therapy requirements). This means that in order to receive Benefits for such Prescription Drug Products or Pharmaceutical Products you are required to use a different Prescription Drug Products(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to Step Therapy requirements through the Internet at www.welcometouhc.com/shbp or log on www.myuhc.com or by calling Customer Care at the number on your ID card.

Clinical Appeal Process

If a notification, quantity limitation, and/or Progression Rx request is denied by UnitedHealthcare, you or your physician may initiate the clinical appeals process.

UnitedHealthcare recommends that a physician initiate an appeal for a denied Notification decision by UnitedHealthcare so that all necessary clinical information can be obtained.

The physician's request/appeal must be submitted in writing (via letter) to us for consideration. A physician must submit an appeal within 180 calendar days of the date of the denial letter. This is known as the first-level appeal. The written inquiry should be directed to:

State of Georgia Health Benefit Plan Members

6220 Old Dobbin Lane

Columbia, MD 21045

UnitedHealthcare will advise the physician and the member, in writing, of its decision. If UnitedHealthcare upholds the denial, information regarding the second-level appeal process will be provided to the physician and the member.

Second-level appeals (an appeal to the first-level appeal decision described above) must be initiated by you or your physician and, must be received in writing (via letter). UnitedHealthcare recommends that a physician initiate an appeal for a denied first-level appeal decision by UnitedHealthcare so that all necessary clinical information can be obtained. The second level appeal must be submitted within 60 days of the date of the first level appeal denial letter.

The second-level appeal request, along with any new and/or additional supporting documentation shall be forwarded to UnitedHealthcare to the address above. **The second level appeal decision is the final decision.**

If, after exhausting the two levels of appeal, you are not satisfied with the final determination, you may choose to participate in the external review program. This program only applies if the adverse benefit determination is based on:

- clinical reasons; or
- the exclusions for Experimental or Investigational Services or Unproven Services.

The external review program is not available if the adverse benefit determination is based on explicit benefit exclusions or defined benefit limits. Contact UnitedHealthcare at the toll-free number on your ID card for more information.

How to Fill Your Prescription At An Out-of-Network Pharmacy or At a Network Pharmacy When you Do Not Present Your ID Card

When you use an Out-of-Network pharmacy or if you do not show your ID card or provide verifiable information at a Network pharmacy, you must pay the Full Retail Cost (Usual and Customary Charge) for your prescription and then submit a claim form to UnitedHealthcare for reimbursement of covered drug costs. Assignment of Benefits (AOB) is not available.

If you wish to seek reimbursement, you may obtain a prescription drug claim form from UnitedHealthcare by calling the Customer Care number on ID card or through the Internet at www.welcometouhc.com/shbp or log on www.myuhc.com. The prescription drug claim form is also available in electronic format on the Department of Community Health web site: www.dch.georgia.gov/shbp. You may print a copy of the claim form from this web site. Along with the prescription drug claim form you will need a receipt for your prescription or an explanation of benefits from your primary carrier (if applicable).

The prescription drug claim form must be filled out in its entirety. Any missing information may cause a delay in processing your reimbursement. Required information includes the pharmacy seven-digit NCPDP number (this number should be identified on your pharmacy receipt), the National Drug Code (NDC) number for your prescription (this can be obtained from your pharmacy), the prescription number, the name of the pharmacy, the physician's name, the member ID number, the patient's name, and the patient's date of birth. A pharmacy receipt or an explanation of benefits from your primary carrier (if applicable) is also required with the claim form.

You may request reimbursement from us as described in the Summary Plan Description Section 6: How to File a Claim. You must submit your pharmacy receipt and claim form to the address identified on the claim form. You will be reimbursed the prescription drug cost less the applicable Coinsurance. Also, you are subject to benefit plan rules (including but not limited to Notification and Step Therapy) as well as balance billing if the charged amount exceeds the network cost of your prescription(s).

Coordination of Benefits (COB)

If your spouse or a dependent has primary coverage from another health plan or if you or your spouse as a retiree have a Medicare Part D plan, prescription drug benefits provided by the State Health Benefit Plan (SHBP) will be coordinated with the other insurance carrier(s). This means you must first use your primary insurance plan when you pay for your prescription(s).

To request a secondary payment from UnitedHealthcare at the time of purchase you can request the Pharmacist to electronically file SHBP secondary (see below).

Coordination of Pharmacy Benefits between your Prescription Drug Plan (PDP) and SHBP

- If you have a Medicare Part D plan as primary, each time you go to the pharmacy, present both your Medicare Part D and SHBP identification cards.
- When Medicare coordination of benefits occurs, you should not be responsible for more than your SHBP coinsurance for eligible charges.
- When you reach the PDP coverage gap, you should still present both identification cards and you will pay your SHBP coinsurance.
- Please note that to be eligible for reimbursement when coordinating pharmacy benefits with your primary insurance carrier, it is your responsibility to make sure any prescriptions subject to specific benefits rules such as notification and Step Therapy receive approval before your claims may be considered for reimbursement.

Coordination of Pharmacy Benefits between your Primary Prescription Drug Plan and SHBP

- If you have another health plan as primary, each time you go to the pharmacy, present both your primary insurance carrier and SHBP identification cards.
- When coordination of benefits occurs, you should not be responsible for more than your SHBP coinsurance for eligible charges.
- Please note that to be eligible for reimbursement when coordinating pharmacy benefits with your primary insurance carrier, it is your responsibility to make sure any prescriptions subject to specific benefits rules such as notification and Step Therapy receive approval before your claims may be considered for reimbursement.

To request a secondary payment from UnitedHealthcare after the time of purchase, you can send a prescription drug claim form and attach a copy of the Explanation of Benefits (EOB) from the primary plan or the pharmacy receipt. You can obtain a copy of the prescription drug claim form by calling the Customer Care number on your ID card or through the Internet at www.welcometouhc.com/shbp or log on www.myuhc.com.

When the SHBP is the Secondary Plan, benefits are coordinated to pay only the difference between the amount paid by the Primary

Plan and the allowable amount payable by the SHBP, less any applicable coinsurance.

Note: The amount paid will not exceed the allowable amount payable by the SHBP, less any applicable coinsurance.

Please contact UnitedHealthcare at the Customer Care number on your ID card for more details.

If you have coverage under two State Health Benefit Plan contracts (cross-coverage), prescription drug benefits provided by the State Health Benefit Plan will not be coordinated. Coinsurance will be required for each filled prescription. If you have coverage under a Medicare Advantage plan benefits provided by the State Health Benefit Plan pharmacy benefits will not be coordinated.

What You Must Pay

You are responsible for paying the applicable Coinsurance amount described in the Benefit Information table, in addition to any Ancillary Charges when Prescription Drug Products are obtained from a Network or Out-of-Network Retail Pharmacy or Network Mail Order Pharmacy or Specialty Designated Pharmacy.

The Ancillary Charge applies when you request the Pharmacist to dispense a brand name drug when a generic equivalent at a lower cost is available.

Payment Information

Payment Term	Description	Amounts
Coinsurance	Coinsurance for a Prescription Drug Product at a Network Pharmacy can be either a specific dollar amount and/or a percentage of the Prescription Drug Cost. Your Coinsurance is determined by the State Health Benefit Plan. **NOTE:** Your Coinsurance for a Prescription Drug Product at a Network or Out-of-Network Pharmacy (filed with a prescription drug claim form) does not apply to your deductible or out of pocket maximum. **Coinsurances will not be overridden or changed on an individual basis.**	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying: • The applicable Coinsurance or • The applicable Coinsurance and Ancillary Charge or • The Network Pharmacy Usual and Customary Charge which includes a dispensing fee and may include sales tax for the Prescription Drug Product. For Prescription Drug Products at a Mail Order Network Pharmacy or a Specialty Designated Pharmacy, you are responsible for paying: • The applicable Coinsurance or • The applicable Coinsurance and Ancillary Charge • The Prescription Drug Cost for that Prescription Drug Product. ***See the Coinsurance stated in the Benefit Information table for amounts.*** You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications. Benefits for Preventive Care Medications are not subject to payment of the Annual Deductible.

Benefits for Preventive Care Medications

Benefits under the Prescription Drug Plan include those for Preventive Care Medications as defined under Section 3, Glossary of Defined Terms. You may determine whether a drug is a Preventive Care Medication through the internet at www.myuhc.com or by calling UnitedHealthcare at the toll-free telephone number on your ID card.

Description of Pharmacy Type and Supply Limits	Your Coinsurance Amount

Prescription Drugs from a Retail Network Pharmacy

Benefits are provided for outpatient Prescription Drug Products dispensed by a Retail Network Pharmacy. The following supply limits apply:

- As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.
- A one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay a Coinsurance for each cycle supplied.

Active Employees that enroll in the Disease Management Program for Diabetes, Congestive Heart Failure (CHF) and Asthma may qualify for an Rx Coinsurance waiver. You must contact Care Coordination to enroll.

(Please note: For covered prescription drug products dispensed from an Out-of-Network pharmacy same rules apply for reimbursement.)

* If you request a brand name Prescription Drug Product in place of the chemically equivalent Prescription Drug Product (generic equivalent) you will pay the applicable Coinsurance in addition to Ancillary Charges.

* ***Note:*** **Pharmacy Benefits apply only if your prescription is for a Covered Health Service, and not for Experimental or Investigational, or Unproven Services. Otherwise, you are responsible for paying 100% of the cost.**

Your Coinsurance is determined by the tier to which UnitedHealthcare's Prescription Drug List Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Please consult your PDL or access www.myuhc.com through the Internet, or call the Customer Care number on your ID card to determine tier status.

Coverage up to 31-day supply for Network Retail Pharmacy

Tier 1 -15% ($20 min/$50 max)

Tier 2 -25% ($50 min/ $125 max)

Tier 3-25% (($80 min/$125 max)

Prescription costs do not apply to deductible or out of pocket maximum.

Coinsurances will not be overridden or changed on an individual basis.

Coverage up to 31-day supply for Retail Non-Network Pharmacy

Tier 1-40%

Tier 2-40%

Tier 3-40%

Description of Pharmacy Type and Supply Limits	Your Coinsurance Amount
Prescription Drugs from a Retail Out-of-Network Pharmacy Benefits for outpatient Prescription Drug Products dispensed by a Retail Out-of-Network Pharmacy. If the Prescription Drug Product is dispensed by a Retail Out-of-Network Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed and then file a claim for reimbursement with us, as described in your Summary Plan Description. We will not reimburse you for the difference between the Predominant Reimbursement Rate and the Retail Network Pharmacy's Usual and Customary Charge (which includes a dispensing fee and sales tax) for that Prescription Drug Product. We will not reimburse you for any non-covered drug product. In most cases, you will pay more if you obtain Prescription Drug Products from an Out-of-Network Pharmacy. The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay a Coinsurance for each cycle supplied. **Specialty Prescription Drug Products are not eligible for coverage if obtained from an Out-of-Network Pharmacy**.	**Prescription costs do not apply to deductible or out of pocket maximum.** **Coinsurances will not be overridden or changed on an individual basis.**

Description of Pharmacy Type and Supply Limits	Your Coinsurance Amount
Specialty Prescription Drug Products from a Specialty Designated Pharmacy For Benefits provided for outpatient Specialty Prescription Drug Products dispensed by a Specialty Designated Pharmacy, the following apply: • As written by a Physician. • Up to a 31-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits. • When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a 31-day supply, the Coinsurance that applies will reflect the number of days dispensed. You must use a Specialty Designated Pharmacy to receive coverage for Specialty Prescription Drug Products. If you do not use a Specialty Designated Pharmacy, the specialty prescription Drug Product is not eligible for coverage and you will be required to pay the Full Retail Cost for that prescription at the pharmacy. Initially, you may obtain the first two (2) fills of your specialty Prescription Drug Product from a Network Retail Pharmacy. Thereafter, you will be required to use a Network Specialty Designated Pharmacy to continue coverage for your Specialty Prescription Drug Product. You will pay the Network coinsurance. **Please note if you use a non-specialty Designated Pharmacy, your specialty prescription is not eligible for coverage and you will be required to pay the full retail cost for that prescription at the pharmacy.** **Specialty medications are not a part of the Mail Order (Home Delivery) benefit.** After the first fills, in order to continue to receive in-network benefits, you must use a specialty Designated Pharmacy. You can continue to fill you non-specialty prescriptions at a regular participating Retail or Mail Order pharmacy.	**Coverage up to 31-day supply for Network Retail Pharmacy:** Tier 1 -15% ($20 min/$50 max) Tier 2 -25% ($50 min/ $125 max) Tier 3-25% (($80 min/$125 max) **Prescription costs do not apply to deductible or out of pocket maximum.** If you request a brand name Prescription Drug Product in place of the chemically equivalent Prescription Drug Product (generic equivalent) you will pay the applicable Coinsurance in addition to Ancillary Charges **Coinsurances will not be overridden or changed on an individual basis.**

Description of Pharmacy Type and Supply Limits	Your Coinsurance Amount
Maintenance Prescription Drugs from a Retail Network and Out-of-Network Pharmacy Maintenance Prescription Drug products are medications taken on an ongoing basis for the treatment of chronic conditions such as diabetes, ulcers or high blood pressure. You may obtain up to a 90-day supply if your physician writes a prescription for a 90 day supply (for example if you take 2 tablets a day, your physician must write a prescription for a quantity of 180 tablets to be dispensed). Maintenance medications include: • Anti-Parkinson medications; • Asthma medications that are taken orally, excluding inhalers; • Cardiovascular medications for hypertension and heart disease; • Diabetic medications; • Estrogen and Progestin medication; • Medications for the treatment of epilepsy; • Oral Contraceptives and; • Thyroid medications. * If you request a brand name Prescription Drug Product in place of the chemically equivalent Prescription Drug Product (generic equivalent) you will pay the applicable Coinsurance in addition to Ancillary Charges.	**Retail Network and Out-of-Network Pharmacy Coverage up to 90-day supply:** Tier 1 -15% ($60 min/$150 max) Tier 2 - 25% ($150 min/$240 max) Tier 3- 25% ($240 min/$375 max) **Prescription costs do not apply to deductible or out of pocket maximum.** **Coinsurances will not be overridden or changed on an individual basis.**

Description of Pharmacy Type and Supply Limits	Your Coinsurance Amount
Prescription Drug Products from a Mail Order (Home Delivery) Network Pharmacy Benefits for outpatient Prescription Drug Products dispensed by a Mail Order Network Pharmacy. The following supply limits apply: • As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. Your doctor must write your prescription for a 90-day or 3-month supply with refills when appropriate (not a 1-month supply with three refills). **Please note you will be charged a Mail-Order Coinsurance regardless of the days supply written on the prescription.** To obtain your prescription from a Mail Order Network Pharmacy, simply follow the instructions below and pay the applicable Coinsurance. 1. Call the toll free phone number on the back of your ID Card or 2. Log onto www.myuhc.com To receive the maximum Benefit, you should ask your provider to write your Prescription Order or Refill for the full 90 days. Active Employees that enroll in the Disease Management Program for Diabetes, Congestive Heart Failure (CHF) and Asthma may qualify for an Rx Coinsurance waiver. You must contact Care Coordination to enroll.	**Mail Order (Home Delivery) Network Pharmacy Coverage up to a consecutive 90-day supply:** Tier 1 -15% ($50 min/$125 max) Tier 2-25% ($125 min/$200 max) Tier 3-25% ($200 min/$312.50 max) **Prescription costs do not apply to deductible or out of pocket maximum.** **Coinsurances will not be overridden or changed on an individual basis.**

Description of Pharmacy Type and Supply Limits	Your Coinsurance Amount
When you obtain a maintenance supply of drugs from a Mail Order Network Pharmacy, your cost sharing may be lower. UnitedHealthcare offers two ways to obtain up to a 90 day supply of maintenance drugs. 1. Some retail pharmacies in our Network allow you to get maintenance drugs up to a 90 day supply. Some of these retail pharmacies may agree to accept the mail order cost sharing amount for maintenance drugs. Other retail pharmacies may not agree to accept the mail order cost sharing amount for maintenance drugs. Your pharmacy directory lists which pharmacies can give you a maintenance drug for your Mail Order benefit. Your pharmacy directory is located at www.welcometouhc.com/shbp 2. You can use the UnitedHealthCare Network Mail Order Network Pharmacy. Mail Order from an Out-of-Network Pharmacy is NOT covered.	

Section 2: What's Not Covered--Exclusions

Exclusions from coverage listed in the Summary Plan Description apply also to this Rider. In addition, the following exclusions apply:

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Drugs which are prescribed, dispensed or intended for use while you are an inpatient in a Hospital, Skilled Nursing Facility, or Alternate Facility.
3. Experimental, Investigational or Unproven Services and medications; medications and/or indications not approved by the Food and Drug Administration (FDA) used for experimental indications and/or dosage regimens determined by UnitedHealthcare to be experimental, investigational or unproven.
4. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
5. Prescription Drug Products for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
6. Any product dispensed for the purpose of appetite suppression and other weight loss products.
7. An injectable medication Prescription Drug Product (including, but not limited to, immunizations and allergy serum) which, due to its characteristics as determined by UnitedHealthcare, must typically be administered or supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to Gardasil, Ceravix and Zostavax vaccines and self-administered injectable medications covered through your pharmacy benefit plan.
8. Administration fees and/or charges for the administration of an injectable Prescription Drug Product.
9. The cost of labor and/ additional charges for compounding prescriptions excluding contractual dispensing fees that pharmacies charge.
10. Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
11. General vitamins, except the following which require a prescription: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
12. Medications used for cosmetic purposes.
13. Prescription Drug Products, including New Prescription Drug Products or new dosage forms that are determined to not be a Covered Health Service.

14. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
15. Infertility drugs/reproduction medicines for treating a diagnosis of infertility.
16. Prescription Drug Products when prescribed to treat infertility. (coverage for Infertility drugs may be approved for a medical diagnosis not related to infertility treatment if the medical diagnosis meets the definition of a Covered Health Service and is not an Experimental, Investigational, or Unproven Service. UnitedHealthcare must be contacted by your physician to determine coverage.)
17. Prescription Drug Products for tobacco cessation (except for Over-the-Counter and Prescription Drug Products prescribed for participation in the Tobacco Cessation Telephonic Coaching Program).
18. Compounded drugs that do not contain at least one covered ingredient that requires a prescription.
19. Drugs available over-the-counter that do not require a prescription by federal or state law before being dispensed (except for the certain preventive OTC drugs – Aspirin, Fluoride, Folic acid and Iron which require a prescription for coverage). Any Prescription Drug Product that is therapeutically equivalent to an over-the-counter drug. Prescription Drug Products that are comprised of components that are available in over-the-counter form or equivalent.
20. New Prescription Drug Products and/or new dosage forms until the date they are reviewed by UnitedHealthcare's Prescription Management Committee.
21. Yohimbine.
22. Mifeprex.
23. Blood or blood plasma products.
24. Growth hormone used for the treatment of short stature in the absence of identified sickness or injury.
25. Specialty Prescription Drugs purchased at a pharmacy that is not a Specialty Designated Pharmacy (except for the first two prescription fills of the Specialty Prescription Drug, which may be purchased from a Retail Network or Mail Order Network pharmacy or an authorized Network pharmacy approved by UnitedHealthcare).

Section 3: Glossary of Defined Terms

This section:

- Defines the terms used throughout this Rider. Other defined terms used throughout this Rider can be found in Section 11: Glossary of Defined Terms of your Summary Plan Description.
- Is not intended to describe Benefits.

Ancillary Charge - a charge, in addition to the Co-insurance, that you are required to pay when a covered Prescription Drug Product is dispensed at your request, when a chemically equivalent Prescription Drug Product is available. For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is calculated as the difference between the Prescription Drug Cost or MAC list price for Network Pharmacies for the brand name Prescription Drug Product and the Prescription Drug Cost or MAC list price of the chemically equivalent Prescription Drug Product available.

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that UnitedHealthcare identifies as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by UnitedHealthcare.

Designated Pharmacy - a pharmacy that has entered into an agreement on behalf of the pharmacy with UnitedHealthcare or with an organization contracting on its behalf, to provide specific Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Full Retail Cost - also known as usual and customary charges. This is the amount that a pharmacist would charge a cash-paying customer for a prescription.

Generic - a Prescription Drug Product: (1) that is chemically equivalent to a Brand-name drug; or (2) that UnitedHealthcare identifies as a Generic product based on available data resources including, but not limited to, Medispan, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by UnitedHealthcare.

Mail Order (Home Delivery Service) - allows members requiring long-term prescriptions the convenience of having long-term medications delivered to the home or office by, the Plan's mail order pharmacy (a pharmacy whose primary business is to dispense prescription drugs or devices under prescription drug orders and to deliver the drugs or devices, usually to patients' homes, by US mail, a common carrier, or a delivery service).

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Network Pharmacy - a pharmacy that has:

- Entered into an agreement with UnitedHealthcare or its designee to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by UnitedHealthcare as a Network Pharmacy.

A Network Pharmacy can be either a Retail or a Mail Order, or Specialty Designated pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the FDA, and ending on the earlier of the following date December 31st of the following Plan year.

Prescription Drug Cost - the rate we have agreed to pay our Network Pharmacies, including a dispensing fee and any sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug Product - a medication, product or device that has been approved by the Food and Drug Administration and that can, under federal or state law, be dispensed only pursuant to a Prescription. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Plan, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:

— standard insulin syringes with needles;

— blood-testing strips - glucose;

— urine-testing strips - glucose;

— ketone-testing strips and tablets;

— lancets and lancet devices;

— Glucose monitors.

Preventive Care Medications – the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance, Annual Deductible, Annual Prescription Drug Deductible or Specialty Prescription Drug Annual Deductible) as required by applicable law under any of the following:

- evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force;*
- with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration; or*
- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.*

You may determine whether a drug is a Preventive Care Medication through the internet at **www.myuhc.com** or by calling UnitedHealthcare at the toll-free telephone number on your ID card.

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Specialty Designated Pharmacy - a specialty pharmacy that has entered into an agreement on behalf of the pharmacy with UnitedHealthcare or with an organization contracting on its behalf, to provide specific Specialty Prescription Drug Products.

Specialty Prescription Drug Product– Prescription Drug Product that is generally high cost, self-injectable biotechnology drug used to treat patients with certain illnesses. Specialty Prescription Drugs include certain drugs for Oncology. You may access a complete list of Specialty Prescription Drugs through the Internet at **www.myuhc.com** or by calling the number on the back of your ID card.

Usual and Customary Charge - the amount that a pharmacist would charge a cash-paying customer for a prescription.

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Section 4: Frequently Asked Questions

This section:

- Help you understand your medication choices and make informed decisions.
- Help you understand which questions to ask your doctor or pharmacist.

What is a Prescription Drug List (PDL)?

A PDL is a list of Food and Drug Administration (FDA)-approved brand name and generic medications.

The UHC Prescription Drug List (PDL) is one way you can find out the tier status and specific rules linked to your medication. The PDL lists the most commonly prescribed medications for certain conditions.

The PDL offers a wide choice of brand name and generic medications that are reviewed by doctors and pharmacists on our National Pharmacy and Therapeutics Committee. The list is updated to reflect decisions based on new medical evidence and information. Additionally, the United States Food and Drug Administration (FDA) approves all medications, including generics, which means you can be confident that whatever medication you choose, it meets the strict guidelines set by the FDA.

Your UnitedHealthcare pharmacy benefit provides coverage for a comprehensive selection of prescription medications. You can check which medications are on which tiers at www.myuhc.com. You and your doctor may refer to this list to consider prescription medication choices and select the appropriate medication to meet your needs.

Understanding Tiers

Prescription medications are categorized within three tiers. Each tier is assigned a coinsurance, the amount you pay when you fill a prescription, which is determined by your health plan. Consult your benefit plan documents to find out the specific coinsurance that are part of your plan. You and your doctor decide which medication is appropriate for you.

Tier 1 Your Lowest-Cost Option	Tier 2 Your Midrange-Cost Option	Tier 3 Your Highest-Cost Option
Tier 1 medications are your lowest coinsurance option. For the lowest out-of-pocket expense, always consider Tier 1 medications if you and your doctor decide they are right for your treatment.	Tier 2 medications are your middle coinsurance option.	Tier 3 medications are your highest coinsurance option. If you are currently taking a medication in Tier 3, ask your doctor whether there are lower-cost Tier 1 or Tier 2 medications that may be right for your treatment.

Note: Compounded medications are medications with one or more ingredients that are prepared "on-site" by a pharmacist. These are classified at the Tier 3 level.

What factors are looked at when making tier placement decisions and who decides which medications get placed in which tier?

Several factors are considered when deciding the placement of a medication on the UHC Prescription Drug List including the medication's classification. Several committees contribute and evaluate the overall value of the medication to ensure an unbiased approach. Committee members are various health care professionals including pharmacists and physicians with a broad range of specialties.

The two main committees are:

Our National Pharmacy and Therapeutics (P&T) Committee evaluates clinical evidence in order to determine a medication's role in therapy and its overall clinical value. In addition, the P&T Committee reviews the relative safety and efficacy of the medication.

The UnitedHealthcare PDL Management Committee evaluates the clinical recommendations of the P&T committee as well as pharmacoeconomic and economic information. Once a medication's clinical, pharmacoeconomic and economic value is established, our PDL Management Committee makes a tier placement decision based on the overall value of the medication.

The PDL Management Committee helps to ensure access to a wide range of affordable medications for you.

How often will prescription medications change tiers?

Most tier changes will occur on January 1 and July 1. Medications may move to a lower or higher tier. Additionally, when a brand name medication becomes available as a generic, the tier status of the brand name medication and its corresponding generic will be evaluated. When a medication changes tiers, you may be required to pay more or less for that
medication. These changes may occur without prior notice to you. For the most current information on your pharmacy coverage, please call our Customer Care number on your ID card or through the Internet at www.welcometouhc.com/shbp or log on www.myuhc.com.

What is the difference between brand name and generic medications?

Generic medications contain the same active ingredients as brand name medications, but they often cost less. Generic medications become available after the patent on the brand name medication expires. At that time, other companies are permitted to manufacture an FDA-approved, chemically equivalent medication. Many companies that make brand name medications also produce and market generic medications.

The next time your doctor gives you a prescription for a brand name medication, ask if a generic equivalent is available and if it might be appropriate for you. While there are exceptions, generic medications are usually your lowest in cost. Go to www.myuhc.com to determine if an equivalent generic medication is available.

Why is the medication that I am currently taking no longer covered?

Medications may be excluded from coverage under your pharmacy benefit. For example, a prescription medication may be excluded from coverage when it is therapeutically equivalent to an over-the-counter medication. For possible coverage alternatives please call the Customer Care number on your ID card.

When should I consider discussing over-the-counter or non-prescription medications with my doctor?

An over-the-counter medication can be an appropriate treatment for many conditions. Consult your doctor about over-the-counter alternatives to treat your condition. These medications are not covered under your pharmacy benefit, but they may cost less than your out-of-pocket expense for prescription medications.

What is a maintenance medication program?

Maintenance Prescription Drug products are medications taken on an ongoing basis for the treatment of chronic conditions such as diabetes, asthma or high blood pressure. Maintenance medications are those prescribed medications that a member may obtain for a period of up to 90 days.

You may obtain up to a 90-day supply if your physician writes a prescription for a 90 day supply (for example if you take 2 tablets a day, your physician must write a prescription for a quantity of 180 tablets to be dispensed).

Please call the Customer Care number if you have specific questions regarding whether or not a medication is covered as a maintenance medication. Certain medications have been categorized as maintenance medications.

What maintenance medications are included in the maintenance medication program?

Maintenance medications include:

- Anti-Parkinson medications;
- Asthma medications that are taken orally, excluding inhalers;
- Cardiovascular medications for hypertension and heart disease;
- Diabetic medications;
- Estrogen and Progestin medication;
- Medications for the treatment of epilepsy;
- Oral Contraceptives and;
- Thyroid medications.

Please call Customer Care number on the back of your ID card if you have specific questions regarding whether or not a medication is covered as a maintenance medication.

What are the Supply Limits (SL) programs?

The Supply Limits program defines the maximum quantity that can be dispensed per coinsurance (Quantity Level Limit or QLL) or specified timeframe (Quantity Duration or QD). Supply Limits are based upon the manufacturer's package size, dosing recommendations or guidelines that are included in the FDA labeling, and medical literature and guidelines.

How do the Supply Limit programs work?

If your prescription exceeds the supply limit, your pharmacist will be notified of the quantity covered for your coinsurance. You will have the following options:

- Accept the established quantity limit
- Pay additional out-of-pocket costs or coinsurance amounts that exceed the quantity limits (as appropriate)
- Discuss alternatives with your doctor before deciding whether to fill the prescription
- Request notification (coverage authorization) for the additional amounts through the coverage review process (when available)

What is the Notification program?

Notification (also known as prior authorization or coverage review) is a set of clinical rules designed to support the pharmacy benefit at the time the prescription is dispensed. Applied to a very limited number of medications, Notification requires your doctor to provide additional information to determine whether the use of the medication is covered by your pharmacy benefit and to ensure appropriate use.

How does the Notification program work?

If your medication is included in a Notification program, your pharmacy is sent a message on the computer system with instructions to have your doctor call a toll-free number to get approval for the prescription. Some pharmacists will contact your doctor while others may request you do so. Your doctor will provide UnitedHealthcare with information to determine if the prescription meets the coverage conditions of your pharmacy benefit. We will review the information and approve or deny coverage. We will send letters to you and your doctor explaining the decision and providing instructions on how to appeal if you so desire.

What should I do if I use a self-administered injectable medication?

You may have coverage for self-administered injectable medications through your pharmacy benefit plan or under your medical benefits.

Please call our Customer Care number on your ID card to determine whether or not a medication is covered as a self-administered injectable under your pharmacy or medical benefits.

How do I obtain a supply of my medications before I go on vacation?

When traveling on vacation, each plan year (calendar year), you are allowed to obtain up to a 6 months supply for each prescription to take on vacation.

If you would like to obtain a supply of medication prior to leaving for your vacation, you will need to inform your local network pharmacist. Your pharmacist should know how to process your vacation request however if not please have your pharmacist contact the UnitedHealthcare pharmacy helpdesk at (800) 922-1557.

You may also locate a network pharmacy at your vacation destination by calling the Customer Care number on your ID card or through the Internet at www.welcometouhc.com/shbp or log on www.myuhc.com.

How do I access updated information about my pharmacy benefit?

We encourage you to log on visit www.myuhc.com or visit www.welcometouhc.com/shbp or please call our Customer Care on your ID card for more current information.

Log on to www.myuhc.com for the following pharmacy resources and tools:

- Pharmacy benefit and coverage information
- Specific co-insurance amounts for prescription medications
- Possible lower-cost medication alternatives
- A list of medications based on a specific medical condition
- Medication interactions and side effects, etc.
- Locate a participating retail pharmacy by zip code
- Review your prescription history

What if I still have questions?

Please call our Customer Care on your ID card. Representatives are available to assist you 24 hours a day, except Thanksgiving and Christmas.

End of Outpatient Prescription Drug Rider –

Attachment I

Women's Health and Cancer Rights Act of 1998

The Plan complies with the Women's Health and Cancer Rights Act of 1998. Mastectomy, including reconstructive surgery, is covered the same as other surgery under your Plan option. Following cancer surgery, the SHBP covers:

- All stages of reconstruction of the breast on which the mastectomy has been performed
- Reconstruction of the other breast to achieve a symmetrical appearance
- Prostheses and mastectomy bras
- Treatment of physical complications of mastectomy, including lymphedema

Note: Reconstructive surgery requires prior approval, and all inpatient admissions require prior notification.

For more detailed information on the mastectomy-related benefits available under the Plan, you can contact the Member Services unit for your coverage option. Telephone numbers are on the inside front cover of the Decision Guide.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

The Plan complies with the Newborns' and Mothers' Health Protection Act of 1996.

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Attachment II

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the toll-free number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the toll-free number on the back of your ID card.

Attachment III

Health Insurance Portability and Accountability Act

The Plan complies with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The HIPAA Privacy Notice is attached as Exhibit A. The Notice of Exemption Letter is attached as Exhibit B.

Revised October 1, 2013

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Questions? Call 404-656-6322 (Atlanta) or 800-610-1863 (outside of Atlanta).

The DCH and the State Health Benefit Plan Are Committed to Your Privacy. The Georgia Department of Community Health (DCH) sponsors and runs the State Health Benefit Plan (the Plan). We understand that your information is personal and private. Some DCH employees and companies hired by DCH collect your information to run the Plan. The information is called "Protected Health Information" or "PHI." This notice tells how your PHI is used and shared. We follow the information privacy rules of the Health Insurance Portability and Accountability Act of 1996, ("HIPAA").

Only Summary Information is Used When Developing and Changing the Plan. The Board of Community Health and the Commissioner of the DCH make decisions about the Plan. When making decisions, they review reports that explain costs, problems, and needs of the Plan. These reports never include information that identifies any person. If your employer is allowed to leave the Plan entirely, or stop offering the Plan to a portion of its' workforce, DCH will provide Summary Health Information (as defined by federal law) for the applicable portion of the workforce, This Summary Health Information does not contain names, dates or birth or other identifiers, and may only be used by your employer to obtain health insurance quotes from other sources and make decision about whether to continue to offer the Plan. .

Plan Enrollment Information and Claims Information is Used in Order to Run the Plan. PHI includes two kinds of information. "Enrollment Information" includes 1) your name, address, and Social Security number; 2) your enrollment choices; 3) how much you have paid in premiums; and 4) other insurance you may have. This Enrollment Information is the only kind of PHI your employer is allowed to see. "Claims Information" includes information your health care providers send to the Plan. For example, it may include bills, diagnoses, statements, X-rays or lab test results. It also includes information you send to the Plan. For example, it may include your health questionnaires, enrollment forms, leave forms, letters and recorded telephone calls. Lastly, it includes information about you that is created by the Plan. For example, it includes payment statements and checks to your health care providers.

Your PHI is Protected by Law. Employees of the DCH and employees of outside companies hired by DCH to run the Plan are "Plan Representatives." They must protect your PHI. They may only use it as allowed by HIPAA.

The DCH Must Make Sure the Plan Complies with HIPAA. As Plan sponsor, the DCH must make sure the Plan complies with HIPAA. We must give you this notice. We must follow its terms. We must update it as needed. The DCH is the employer of some Plan Members. The DCH must name the DCH employees who are Plan Representatives. No DCH employee is ever allowed to use PHI for employment decisions.

Plan Representatives Regularly Use and Share your PHI in Order to Pay Claims and Run the Plan. Plan Representatives use and share your PHI for payment purposes and to run the Plan. For example, they make sure you are allowed to be in the Plan. They decide how much the Plan should pay your health care provider. They also use PHI to help set premiums for the Plan and manage costs, but they are never allowed to use genetic information for these purposes. Some Plan Representatives work for outside companies. By law, these companies must protect your PHI. They also must sign "Business Associate" agreements with the Plan. Here are some examples of what they do:

Claims Administrators: Process all medical and drug claims; communicate with Members and their health care providers; and give extra (assistance) to Members with some health conditions.

Data Analysis, Actuarial Companies: Keep health information in computer systems, study it, and create reports from it.

Attorney General's Office, Auditing Companies, Outside Law Firms: Provide legal and auditing help to the Plan.

Information Technology Companies: Help improve and check on the DCH information systems used to run the Plan.

Some Plan Representatives work for the DCH. By law, all employees of the DCH must protect PHI. They also must get special privacy training. They only use the information they need to do their work. Plan Representatives in the SHBP Division work full-time running the Plan. They use and share PHI with each other and with Business Associates in order to help pay claims and run the Plan. In general, they can see your Enrollment Information and the information you give the Plan. A few can see Claims Information. DCH employees outside of the SHBP Division do not see Enrollment Information on a daily basis. They may use Claims Information for payment purposes and to run the Plan.

Plan Representatives May Make Special Uses or Disclosures Permitted by Law. HIPAA has a list of special times when the Plan may use or share your PHI without your authorization. At these times, the Plan must keep track of the use or disclosure.

To Comply with a Law, or to Prevent Serious Threats to Health or Safety: The Plan may use or share your PHI in order to comply with a law, or to prevent a serious threat to health and safety.

For Public Health Activities: The Plan may give PHI to government agencies that perform public health activities. For Research Purposes: Your PHI may be given to researchers for a research project approved by a review board. The review board must review the research project and its rules to ensure the privacy of your information.

Plan Representatives Share Some Payment Information with the Employee. Except as described in this notice, Plan Representatives are allowed to share your PHI only with you, and with your legal personal representative. However, the Plan may inform the employee family member about whether the Plan paid or denied a claim for another family member.

You May Authorize Other Uses of Your PHI. You may give a written authorization for the Plan to use or share your PHI for a reason not listed in this notice. If you do, you may take away the

authorization later by writing to the contact below. The old authorization will not be valid after the date you take it away.

You Have Privacy Rights Related to Plan Enrollment Information and Claims Information that Identifies You.

Right to See and Get a Copy your Information, Right to Ask for a Correction: Except for some reasons listed in HIPAA, you have the right to see and get a copy of information used to make decisions about you. If you think it is incorrect or incomplete, you may ask the Plan to correct it.

Right to Ask for a List of Special Uses and Disclosures: You have the right to ask for a list of special uses and disclosures that were made after April 2003.

Right to Ask for a Restriction of Uses and Disclosures, or for Special Communications: You have the right to ask for added restrictions on uses and disclosures. You also may ask the Plan to communicate with you in a special way.

Right to a Paper Copy of this Notice, Right to File a Complaint without Getting in Trouble: You have the right to a paper copy of this notice. Please contact the SHBP HIPAA Privacy Unit or print it from www.dch.ga.gov. If you think your privacy rights have been violated, you may file a complaint. You may file the complaint with the Plan and/or the Department of Health and Human Services. You will not get in trouble with the Plan or your employer for filing a complaint.

Addresses for Complaints:

SHBP HIPAA Privacy Unit
P.O. Box 1990,
Atlanta, Georgia 30301
404-656-6322 (Atlanta) or 800-610-1863 (outside Atlanta)

U.S. Department of Health & Human Services, Office for Civil Rights
Region IV Atlanta Federal Center
61 Forsyth Street SW, Suite 3B70
Atlanta, GA 30303-8909

Attachment IV

Election to be Exempt from Certain Requirements of HIPAA

October 1, 2012

TO: All Members of the State Health Benefit Plan who are not Enrolled in a Medicare Advantage Option

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must comply with a number of requirements. Under HIPAA, state health plans that are "self-funded" may "opt out" of some of these requirements by making a yearly election to be exempt. Your plan option is self-funded because the Department of Community Health pays all claims directly instead of buying a health insurance policy.

Temporary rules implementing the Mental Health Parity and Addiction Equity Act apply January 1, 2012, unless the Department of Community Health again elects to be exempted from this law's requirements. The temporary rules generated more than 4,000 comments; no final rules addressing these comments have been issued. The Department of Community Health has determined to exempt your State Health Benefit Plan ("SHBP") option from the Mental Health Parity and Addiction Equity Act, and the temporary rules' requirements, for the 2012 calendar year.